

**MORNING STAR PRESCHOOL
2012-13 School Year**



**Parent/Guardian Consent and Agreement
for Emergencies:**

I give consent to have my child receive first aid by the school's staff, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for emergency contact person listed above to act on my behalf until I am available. My child may be released to the contact persons listed on this form. I agree to notify Morning Star Fellowship Preschool of any changes in this information.

Date: _____ Parent/Guardian Signature: _____

Outdoor Play

I give my permission to the staff of Morning Star Preschool to take my child, _____ outdoors for play or a neighborhood walk on any given day as weather permits.

Date: _____ Parent/Guardian Signature: _____

Advertising Permission

_____ give the MSF Preschool and Morning Star Fellowship permission to use photos of _____ for use on

_____ Facebook (Please initial)

_____ Advertising (Please initial)

_____ Web Page (Please Initial)

Date: _____ Parent/Guardian Signature: _____

Morning Star Fellowship
100 Limekiln Road
Bechtelsville, PA 19505
(610) 369-1960
e-mail: preschool@mstar.org or jill@mstar.org

**Morning Star Fellowship Preschool
100 Limekiln Road, Bechtelsville, PA 19505**

Child Health Assessment

Child's Name _____
 DOB _____
 Child Care Facility/School _____ MSF Preschool
 Child Care Facility/School Phone _____ 610-369-1960

Parent/Guardian _____
 Address _____
 Work Phone _____

Note: A copy of the EPSDT exam report attached to a copy of the child's immunization record may be substituted for this form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND EMERGENCIES:

DATE OF EXAM _____

ALLERGIES TO FOOD OR MEDICINE:

LENGTH/HEIGHT IN/CM #ILE _____	WEIGHT LB #ILE _____	HEAD CIRCUMFERENCE IN/CM #ILE _____	BLOOD PRESSURE _____/_____
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PHYSICAL EXAMINATION	NORMAL	ABNORMAL/COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC/TONE		
DEVELOPMENTAL (E.G. DDST)		

IMMUNIZATIONS	BIRTH TO 1 MO	2 MO	4 MO	6 MO	12-18 MO	4-6 YRS	11-12 YRS
DPT							
POLIO							
HIB							
HEP B							
MMR							
OTHER							

Note: Ages and number of boosters may vary when immunization start at older ages.

SCREENING TEST	DATE	NORMAL	ABNORMAL/COMMENTS
LEAD			
ANEMIA (HGB/HCT)			
URINALYSIS (UA)			
TUBERCULOSIS (TB)			
HEARING			
VISION			

Note: Age appropriate health services and immunization must follow the schedule recommended by The American Academy of Pediatrics, 141 Northwest Point Blvd, Elk Grove Village, IL 60007

HEALTH PROBLEMS OR SPECIAL NEEDS _____
 RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (Attach additional sheets if necessary)

MEDICAL CARE PROVIDER: _____

ADDRESS: _____

PHONE: _____

NEXT APPOINTMENT: MONTH _____ YEAR _____

DATE _____ SIGNATURE OF PHYSICIAN OR CAMP _____

Morning Star Fellowship Preschool
100 Limekiln Rd., Bechtelsville, PA 19505
Emergency Information Sheet

EMERGENCY CONTACT INFORMATION

Child's Name _____ Birth Date _____
Parent/Legal Guardian #1 _____ Home # _____ Work # _____ Cell # _____
Parent/Legal Guardian #2 _____ Home # _____ Work # _____ Cell # _____

My child can be released into the custody of **ONLY THE PERSONS LISTED BELOW**:

1. _____ Home # _____ Work # _____ Cell # _____
2. _____ Home # _____ Work # _____ Cell # _____
3. _____ Home # _____ Work # _____ Cell # _____

If parents or legal guardians cannot be reached, who should be called?

Name _____ Relationship to child _____
Home # _____ Work # _____ Cell # _____
Name _____ Relationship to child _____

Child's Physician _____
Address _____ Phone # _____

Child's Health Insurance Co. _____
Name on Card _____ ID # _____

Please list any special conditions, disabilities, allergies, other pertinent medical information _____

If necessary, child will be taken to Pottstown Hospital unless noted otherwise here _____

PARENT/GUARDIAN CONSENT AND AGREEMENT FOR EMERGENCIES:

I give consent to have my child receive first aid by the school's staff, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for emergency contact person listed above to act on my behalf until I am available. My child may be released to the contact persons listed on this form. I agree to notify Morning Star Fellowship Preschool of any changes in this information.

Date: _____ Parent/Guardian Signature: _____

Activity Participation Agreement



Activity Information

Name of sponsoring organization MSF Preschool, A Ministry of Morning Star Fellowship
Address: 100 Limekiln Rd., Bechtelsville, PA 19505 Telephone: 610-369-1960
Name of sponsor's coordinator: Liz DeFrain Telephone: 610-369-1960
Description of activity: Wee Workout
Date(s) and location of activity: Monthly activity during the 2011-13 school year

Participant Information (To be completed by participant or authorized guardian)

Name of participant: _____
Name of parents/guardians: _____ Telephone: _____
Address: _____ Telephone: _____
Name of emergency contact: _____
Telephone (Day): _____ Telephone (evening): _____
List allergies or medical conditions: _____
Is sponsor authorized to approve medical treatment? Yes No
Is participant covered by personal/family medical insurance? Yes No
If yes, name of insurer: _____ Policy or group number: _____

Participation Agreement

I acknowledge that participation in the activity described above involves risk to the Participant (and to Participant's parents or guardians, if Participant is a minor), and may result in various types of injury including, but not limited to, the following: sickness, bodily injury, death, emotional injury, personal injury, property damage and financial damage.

In consideration for the opportunity to participate in the activity described above (the "Activity"), the Participant (or parent/guardian if Participant is a minor) acknowledges and accepts the risks of injury associated with participation in and transportation to and from the Activity. The Participant (or parent/guardian) accepts personal financial responsibility for any injury or other loss sustained during the Activity or during transportation to and from the activity, as well as for any medical treatment rendered to the Participant that is authorized by the Sponsor or its agents, employees, volunteers, or any other representatives (collectively referred to hereinafter as the "Activity Sponsor"). Further, the Participant (or parent/guardian) releases and promises to indemnify, defend, and hold harmless the Activity Sponsor for any injury arising directly or indirectly out of the described Activity or transportation to and from the Activity, whether such injury arises out of the negligence of the Activity Sponsor, the Participant, or otherwise.

If a dispute over this agreement or any claim for damages arises, the Participant (or parent/guardian) agrees to resolve the matter through a mutually acceptable alternative dispute resolution process. If the Participant (or parent/guardian) and the Activity Sponsor cannot agree upon such a process, the dispute will be submitted to a three-member arbitration panel for resolution pursuant to the rules of the American Arbitration Association.

Signature: _____ Date: _____
Signature: _____ Date: _____
Signature: _____ Date: _____
(Participant and/or ALL parent/guardians if participant is a minor)