



**CROSSROADS
COMMUNITY
PRESCHOOL**

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Calgary, AB
Canada
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crossroadspreschool.ca

STUDENT INFORMATION FORM

CLASS:

Child's Name:
Surname Given Name (s)

Current Age: Birth Date:
Day / Month / Year

Address: City:

Postal Code: Email Address:

Phone Number (home): Phone Number (cell):

Languages Spoken at Home:

FAMILY INFORMATION

Siblings:
Brothers Sisters

Guardian's Name:

Address: Phone #:

Employer: Address: Phone #:

Guardian's Name:

Address: Phone #:

Employer: Address: Phone #:

EMERGENCY CONTACT	EMERGENCY CONTACT
Name: <input type="text"/>	Name: <input type="text"/>
Address: <input type="text"/>	Address: <input type="text"/>
Phone Number: <input type="text"/>	Phone Number: <input type="text"/>
Relationship with Child: <input type="text"/>	Relationship with the Child: <input type="text"/>

MEDICAL INFORMATION

Are there any medications taken on a regular basis?

Yes ☐ No ☐

Are there any medical or behavioral problems the Preschool Teacher should be aware of? If so, please provide details.

Allergies: _____

Doctor's Name: _____ Phone Number _____

Address: _____

Alberta Health Care Number: _____

**** Please provide photocopy of Alberta Health Care Card ****

Hospitalization: _____
Date _____ Diagnosis _____

Public Health Clinic Attended for Vaccinations _____

**** Please provide photocopy of vaccination record ****

Childhood Illnesses (please mark in date if child has had any of the following)

- | | | | |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> Measels | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Rubella | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Fracture | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Accidental Poisoning |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Convulsions | |

Other (please specify) _____

Date: _____ Guardian Signature: _____