Pre-school Application

Each child will have their own separate file, including the following:

**Identification/Emergency Information/Consent for Medical Treatment (Form A)____________________

**Child’s Pre-Admission Health History/Immunization Record (Form B)____________________

**Check out Approvals (Form C)____________________

**Copy of Birth Certificate____________________

Child’s Name ________________________________________________________________

Staff Signature ______________________________________________________________

Date ________________________________________________________________

Parent / Recreation Center Agreement

I, ________________________________________________________________, agree to pay Bellevue Recreation Center the fees due monthly for pre-school by the designated due date of the first of each month. I understand that failure to make full payment when due will cause my child to be dropped from the program and I may receive verbal notification and a follow-up written notification of such action. I also understand that I will not be accepted into any other Los Angeles city Recreation and Park Pre-school, Recreational classes or sports programs until this debt has been paid in full.

________________________________________  ______________________________

Parent / Guardian Signature  Date
Pre-School Emergency Information

The information below is extremely important for the health and welfare of your child.
Carefully fill out the information below.
It is imperative that this information is correct and current.

Child’s Name: ____________________________________________  Child’s Age: ____________________________
Mother’s Name __________________________________________  Home Phone ____________________________
Mother’s Address ________________________________________  Cell Phone ____________________________
E-Mail Address __________________________________________
Father’s Name __________________________________________  Home Phone ____________________________
Father’s Address ________________________________________  Cell Phone ____________________________
E-Mail Address __________________________________________

In an emergency, (if parents are unavailable), please contact:

Name ______________________________________  Relationship __________________________
Home Phone ______________________________________  Cell Phone __________________________
Name ______________________________________  Relationship __________________________
Home Phone ______________________________________  Cell Phone __________________________

Authorization to Consent to Treatment of Minor

I, the undersigned parent/guardian of ______________________________________, a minor, do hereby authorize
the park representatives as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical
diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special
supervision, of any physician or surgeon licensed under the provision of the Medicine practice Act, or the medical staff of a licensed
hospital, whether such diagnosis or treatment is rendered at the office of said physician or at the said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but it
is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis,
treatment or hospital care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable.

_________________________________________  ____________________________________________
Date  Parent/Guardian Signature  Parent/Guardian Signature

Preferred Hospital __________________________________________

Name  Address  Phone

Doctor’s Name __________________________________________
Pre-Admission Health History/Immunization Record

Child’s Name __________________________________________ Birthdate ________________________________

Immunizations:
Polio Booster dates: ________________________________
DPT Booster dates: ________________________________ (Diphtheria, Whooping Cough and Tetanus)

Has the child had the following (check all that apply)?

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<thead>
<tr>
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<tbody>
<tr>
<td>Chicken Pox</td>
<td>Rheumatic Fever</td>
<td>Colds</td>
<td></td>
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<tr>
<td>Measles</td>
<td>Sinus Trouble</td>
<td>Headaches</td>
<td></td>
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<tr>
<td>German measles</td>
<td>Ear Infection</td>
<td>Fainting</td>
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<tr>
<td>Mumps</td>
<td>Tonsillitis</td>
<td>Constipation</td>
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<tr>
<td>Scarlet Fever</td>
<td>Appendicitis</td>
<td>Stomach Upset</td>
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<tr>
<td>Diphtheria</td>
<td>Asthma</td>
<td>Skin Rash</td>
<td></td>
</tr>
<tr>
<td>Heart Trouble</td>
<td>Hay Fever</td>
<td>Nosebleeds</td>
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</tbody>
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Other ________________________________________________________________

Comments (list those things that are chronic or those that the child has recently contracted):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Allergic Reactions (please list):

**Food (name) ____________________________________________________________
**Bee sting, mosquito, etc. ______________________________________________
**Drugs (i.e. penicillin) ________________________________________________

Operations or serious injuries ____________________________________________

Has child received medical treatment during the past year? ______ If yes, date/reason? ________________________________
Does child take any medication at present? ___________________________ If so, what/reason? ________________________________

**Bellevue staff will not be responsible for administering any type of medication. There will be no exceptions.**

If anything happens to the child that would alter this health history report, please inform the Bellevue staff immediately.
Form C

CHECK OUT APPROVALS

Child’s Name: __________________________________________________________

Child’s Age: __________________________________________________________

Birthdate: ____________________________________________________________

Only the following are authorized to pick up my child (include yourself and any other applicable persons):

Name ___________________________________________ Relationship _________

Name ___________________________________________ Relationship _________

Name ___________________________________________ Relationship _________

Name ___________________________________________ Relationship _________

Name ___________________________________________ Relationship _________

Name ___________________________________________ Relationship _________

Name ___________________________________________ Relationship _________

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