

Student's Name _____ Birthday _____

Home Address _____

City _____ Zip _____

Home Phone () _____ Cell Phone () _____

Father's Name _____ Work Phone () _____

Place of Employment _____

Mother's Name _____ Work Phone () _____

Place of Employment _____

Name of responsible adult who will assure responsibility for the child if the parents cannot be reached:

Name _____ Relationship to student _____

Phone () _____ Address _____

Family Doctor _____ Office Phone () _____

Address _____

Emergency Medical Authorization: If you or the above doctor cannot be reached in an emergency, and if in the judgment of the teacher, coach, or other authorized supervisory person, immediate medical and/or hospital attention is indicated, do you authorize responsible authorities to take your child, properly accompanied to an available hospital or doctor?

Yes ___ No ___ Parent/Guardian Signature _____

Does your child have any physical disability or limitations? Yes___ No___

Comments:

Does your child have any allergies? Yes___ No___

Comments:

Is your child under a doctor's care at this time? Yes___ No___

Comments:

Is your child taking any medication? Yes___ No___

Comments:

Is your child allergic to any medication? Yes___ No___

Comments:

Date of last tetanus shot _____

This form will be kept on file with the school and a copy will accompany students who are involved in school functions. Please list any comments on reverse side.

PLEASE INFORM THE SCHOOL IMMEDIATELY IF THERE ARE ANY CHANGES IN THIS INFORMATION.