INFORMATION SHEET

In making out this report the school has no other motives than to benefit the safety and well-being of the student.

STUDENT'S NAME _____
Last First Middle

STUDENT'S BIRTHDATE _____
Month Day Year

STUDENT'S PLACE OF BIRTH _____
City State County

FATHER'S NAME (living in home) _____

MOTHER'S NAME (living in home) _____

ADDRESS _____
House Number Street City

_____
Post Office Box Number

HOME PHONE _____

WORK PHONE _____ _____
Mother Work Place

_____ _____
Father Work Place

If student is not residing with natural parents, with whom does the student reside:

_____

List the person(s) names and phone numbers who have your permission to assume temporary care of the student (i.e. take students out of school, student may go home to, pick student up for appointments, student to engage in conversation (phone or office visit), etc.

_____

_____

_____

Special Instructions we need to be aware of relative to the release and safety of student. (Example: Ex-spouse Do they have the right to see, speak to, remove child from school, etc.)

_____

_____

_____

_____

____ Please check if your address or phone number has changed 5341 F1

Emergency Medical Authorization

Student Name _____ Date of Birth _____

Address_____ Phone _____

School_____ Grade_____ Homeroom_____ Bus No._____

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Mother _____ Home #_____Work #_____ Cell #_____

Father _____ Home #_____ Work #_____ Cell #_____

Guardian_____ Home #_____Work #_____ Cell #_____

Stepparent_____ Home #_____Work #_____ Cell #_____

If my child becomes ill at school and attempts to contact me have been unsuccessful, I authorize the school to call the following persons who are authorized to pick up my child:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor_____ Phone_____ Dentist_____ Phone_____

Preferred Hospital_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

_____

Date_____ Signature of Parent/Guardian_____

PART II – REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

Date_____ Signature of Parent/Guardian_____