

## Student Registration, Health Information and Emergency Treatment Permission Statement

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

**Last Name / First Name / Full Middle Name**

Birth Date / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Race/ Ethnicity</b>	<input type="checkbox"/> Amer. Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Multi <input type="checkbox"/> Black <input type="checkbox"/> White
Birth City	Birth County	Birth State	Soc. Sec. #
<b>PARENT INFORMATION</b>		<input type="checkbox"/> Mother <input type="checkbox"/> Step-Mother <input type="checkbox"/> Guardian	<input type="checkbox"/> Father <input type="checkbox"/> Step-Father <input type="checkbox"/> Guardian
Name: First (Maiden) Last			
Street Address			
Mailing Address (if different)			
City/State/Zip			
Home Phone Number			
Cell Phone Number			
Place of Employment			
Work Phone Number			
Email Address			
Custody (if separated or divorced)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Siblings in this school district: <b>List names and grade.</b>			

It is your responsibility to make arrangements for proper care in case your child should have an accident or become ill while attending school. Should you be away from home, the following will help you and your child in receiving proper care and notification.

- 1.) Designate a neighbor or relative to care for your child in their home until you can be reached.
- 2.) Inform designated persons that you have used their names and advise them of their responsibilities.
- 3.) If any information should change during the school year please notify the Building Principal or Secretary

**IF MY CHILD BECOMES ILL AND I CANNOT BE REACHED, PLEASE NOTIFY:**

	Name	Relationship	Daytime Phone	Cell Phone
First Contact				
Second Contact				

HEALTH INFORMATION (If medication is to be given at school, please complete & attach required consent form.)

✓	Medical Condition (Check all that apply)	Give Details of Condition – Treatment/Medication/Dosage Instructions
	ADD/ADHD	
	Allergies-Food/Medicine/Insects	Epi-Pen? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Asthma	Inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Diabetes	
	Ear Infections/Hearing Problems	Hearing Device? <input type="checkbox"/> Yes <input type="checkbox"/> No Last Exam Date:
	Heart Condition	
	Pneumonia	
	Rheumatic Fever	
	Scarlet Fever	
	Seizure Disorder	
	Tonsillitis	
	Vision Problems	Glasses/Contact Lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Last Exam Date:
	Other Serious Illness/Injury (Describe)	
Check here if more medical information is provided below.		

I give my permission for the administration of Acetaminophen (generic version of Tylenol) or Ibuprofen during this school year.

Parent Signature \_\_\_\_\_