

Parent living elsewhere: _____ Home Phone Number: _____ Mailings? Yes No

Address: _____
Number/Street Name City State Zip Code

Custody Issues: _____

Emergency Contact Person (Other than Parent)	Phone Number	Relationship
(1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____
(4) _____	_____	_____

Does your child attend a day care center or go to a sitter after school? Yes No

If yes, _____
Number/Street Name City State Zip Code

Emergency medical conditions/problems: (check ALL that apply)

- hemophiliac diabetic epileptic asthma contact lenses wears glasses
 peanut allergy bee sting allergy

Other medical conditions that may affect your child at school: _____

Allergies (please list food, medication, and environmental allergies): _____

Medications (please list medications that your child is currently taking): _____

The Family Rights and Privacy Act requires your signature for disclosure of any medical problems your child may have. Your signature will allow release of medical information to school or medical personnel to better serve your child.

Name of Physician: _____ Phone: _____

Physician Address: _____
Number/Street Name City State Zip Code

Parent/Guardian Signature: _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated on this form and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangement necessary. **Note to parents:** No medications will be administered by school personnel without written directions from parent.

Parent/Guardian Signature: _____

I affirm, that as the parent/legal guardian, all information provided above is true and accurate, and that my child and I reside at the listed address. I understand any false information provided by me, may subject me to legal penalties for perjury.

Parent/Guardian Signature: _____ Date: _____