SETON FOUNDATION FOR LEARNING

PLEASE PRINT

FAMILY LAST NAME: ______________________________

CHILD FIRST NAME: ______________________________

HOME ADDRESS: ______________________________ HOME PHONE ______________

CITY, STATE, ZIP ______________________________

FATHER'S/GUARDIAN'S FULL NAME ______________________________ WORK PHONE ______________

CELL PHONE ______________

MOTHER'S/GUARDIAN'S FULL NAME ______________________________ WORK PHONE ______________

CELL PHONE ______________

OTHER ADULTS AUTHORIZED TO PICK UP

NAME: ______________ RELATIONSHIP ______________ CELL PHONE ______________

NAME: ______________ RELATIONSHIP ______________ CELL PHONE ______________

NAME: ______________ RELATIONSHIP ______________ CELL PHONE ______________

IN THE EVENT OF EMERGENCY, WHO WOULD BE AVAILABLE TO PICK UP CHILD (WITHIN 15 MINUTES)? ______________

* Any person unfamiliar to staff will be required to show identification. Under NO circumstances will the student be releases to anyone other than those listed without WRITEN permission.

DOCTOR: ______________________________ DOCTOR PHONE NUMBER: ______________

MEDICAL CONCERNS: ______________________________

ALLERGIES: ______________________________

MEDICATION TAKEN REGULARLY: ______________________________

IN THE EVENT THAT A STUDENT REQUIRES EMERGENCY OR MEDICAL TREATMENT EVERY ATTEMPT WILL BE MADE TO CONTACT THE PARENT/GUARDIAN HOWEVER I AUTHORIZE ANY AND ALL EMERGENCY MEDICAL, DENTAL AND/OR SURGICAL CARE AND HOSPITALIZATION ADVISED BY THE PHYSICIANS, SURGEON OR HOSPITAL NECESSARY FOR THE PROPER HEALTH AND WELL-BEING OF MY CHILD.

PREFERRED HOSPITAL: ______________________________

PARENT/GUARDIAN SIGNATURE: ______________________________ DATE: ______________