

To be completed and signed by parent or guardian

INFORMATION:

Name \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home phone \_\_\_\_\_

In case of accident or sudden illness, please provide the following:

Student lives with:

Mother's name \_\_\_\_\_ Both Parents \_\_\_\_\_

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Mother only \_\_\_\_\_

Father's name \_\_\_\_\_ Father only \_\_\_\_\_

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Joint custody \_\_\_\_\_

Medical Information:

Physician \_\_\_\_\_ Physician Phone \_\_\_\_\_

Preferred Hospital \_\_\_\_\_ Hospital Phone \_\_\_\_\_

Dentist: \_\_\_\_\_ Dentist Phone \_\_\_\_\_

Date of last Tetanus shot \_\_\_\_\_

Health Information:

List any significant or on-going health condition (for example: severe allergies, asthma, ADD, birth defect, diabetes, epilepsy, heart disease, vision or hearing problem) or any other condition relevant to school or athletics. Explain: \_\_\_\_\_

\_\_\_\_\_

Explain Medications taken on a regular basis \_\_\_\_\_

\_\_\_\_\_

Medications Allergic to: \_\_\_\_\_

Insurance Information: \_\_\_None or \_\_\_The Insurance company which covers the above named child is:

Name of Company \_\_\_\_\_ Policy Number \_\_\_\_\_

List two LOCAL people who will temporarily care for your student if you cannot be reached::

Name \_\_\_\_\_ Home phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Name \_\_\_\_\_ Home phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Parent Consent: Parents are expected to transport their own children from school to home or from school to doctor's office except in case of dire emergency. In the event of an emergency or acute illness, we shall attempt to notify the parents first. If neither the parents nor the persons named on this form can be contacted, the school officials are hereby authorized to take whatever action, including the use of an ambulance, is deemed necessary in their judgment for the health of the aforesaid student.

The undersigned, do hereby authorize officials of the Vista Ridge Academy to contact directly the persons named on this form to authorize the named physician or dentist to render such treatment as may be deemed necessary in an emergency for the health of said student. In the event the named physician or dentist is not available at the time of the student's emergency, I hereby authorize the physician or dentist to whom the student is subsequently referred to render such treatment as may be necessary for the health of said student.

I will not hold the Vista Ridge Academy financially or legally responsible for the emergency care and/or transportation to said student.

Signature \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_