VISITATION EXTENDED CARE REGISTRATION

Student Name: _____
last first m.i.

Parent/Guardian: _____

Home Address: _____

Mother's phone: _____
home cell work

Father's phone: _____
home cell work

Emergency out of area contact: _____
name phone relationship

Doctor Name: _____
Dentist Name: _____
name phone

Pertinent Medical Information, Allergies, etc. _____
_____
_____

There must be three day supply of any medications taken that are necessary to sustain life. These should be stored in Extended Care office with a doctor's release form on how and when to administer this medication.

Please list 3 people who are authorized to pick up your child. These people should be prepared to show identification to school personnel.

1. _____
name phone
2. _____
name phone
3. _____
name phone

CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

I_____, the parent/guardian of _____, consent to medical treatment of injuries by a physician or other trained personnel in the event of an emergency. In the event that hospital or surgical care is needed and I am unable to be reached, I authorize consent for treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by a physician in order to safeguard my child's health. I waive my right of informed consent to such treatment.

Parent/guardian signature _____Date_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM