|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| LAST NAME: |  | FIRST NAME: |  |  |
| ADDRESS: |  |  |
| CITY: |  | STATE: |  | ZIP: |  |  |
| HOME PHONE: |  | CELL PHONE:  |  |  |
| EMAIL: |  |  | GRADE: |  | SEX: | F |[ ]  M |[ ]   |
| PARISH: |  | LOCATION: |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| *MOTHER’S INFORMATION:* | *FATHER’S INFORMATION:* |
| NAME: |  |  | NAME:  |  |  |
| WORK PHONE: |  |  | WORK PHONE: |  |  |
| CELL PHONE: |  |  | CELL PHONE: |  |  |
| EMAIL: |  |  | EMAIL: |  |  |
| ADDRESS:  |  |  | ADDRESS: |  |  |
| *\*IF DIFFERENT FROM TEEN* | *\*IF DIFFERENT FROM TEEN* |

|  |
| --- |
| EMERGENCY CONTACT IF PARENT / GUARDIAN IS NOT AVAILABLE: |
| NAME: |  | RELATIONSHIP:  |  |  |
| HOME PHONE: |  | CELL PHONE: |  |  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HEALTH INSURANCE CO: |  | POLICY NUMBER: |  |  |
| PRIMARY CARE PHYSICIAN: |  | PHYSICIAN PHONE #: |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| List any allergies or special needs/concerns/ dietary restrictions, health concerns: |  | List any medications (prescription and non-prescription) currently taking, including dosage: |
| 1. |  |  |  | 1. |  |  |
| 2. |  |  |  | 2. |  |  |
| 3. |  |  |  | 3. |  |  |
| 4. |  |  |  | 4. |  |  |
| 5. |  |  |  | 5. |  |  |
|  |  |  |  |  |

|  |
| --- |
| My child can receive the following medications from the Program Coordinator if needed: (please check boxes below). |
| ASPIRIN | YES |[ ]  NO |[ ]   | ACETAMINOPHEN  | YES |[ ]  NO |[ ]    | IBUPROFEN | YES |[ ]  NO |[ ]
| I give permission for the Diocese of Rochester to make use of pictures of my child for informational/advertising  |
| purposes only for Diocesan programs.  | YES |[ ]  NO |[ ]
|  |

I hereby certify that the above information is correct and give permission for my child to be transported in privately-owned vehicles for medical emergencies only, and for the release of medical records to an attending healthcare professional in case of illness. I understand that every effort will be made to contact the parent/guardian. If one cannot be contacted, I hereby give permission for a qualified physician to secure proper treatment for my child.

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Guardian Signature: |  | Date: |  |