ST. PAUL'S SCHOOL REGISTRATION FORM

STUDENT'S ATTENDING: _____, _____

_____, _____

ADDRESS: _____
STREET *CITY* *ZIP*

HOME PHONE _____

CHURCH AFFILATION: _____

MOTHER'S NAME: _____

ADDRESS: _____
STREET *CITY* *ZIP*

EMPLOYER: _____

WORK NUMBER: _____CELL: _____EMAIL:_____

FATHER'S NAME: _____

ADDRESS: _____
STREET *CITY* *ZIP*

EMPLOYER: _____

WORK NUMBER: _____CELL: _____EMAIL:_____

RESIDES WITH: BOTH PARENTS ( ) MOTHER ( ) FATHER ( ) OTHER ( ) _____

DOCTOR'S NAME: _____

DOCTOR'S ADDRESS: _____

EMERGENCY CONTACTS:

NAME: _____PHONE_____

NAME: _____PHONE_____

NAME: _____PHONE_____

PLEASE WRITE YES OR NO FOR EACH OF THE FOLLOWING:

MAY ADMINISTER NON-ASPRIN: _____

I GRANT PERMISSION FOR MY CHILD(REN) TO GO ON WALKING FIELD TRIPS: _____

I GRANT PERMISSION FOR THE SCHOOL TO USE PICTURES OF MY CHILD(REN) IN PUBLICATIONS: _____

I GRANT PERMISSION TO LIST IN THE SCHOOL DIRECTORIES: PHONE: _____EMAIL:_____ ADDRESS: _____

OVER

STUDENT INFORMATION

STUDENT'S NAME: ____DOB_______________ GRADE________

BOY (   ) GIRL (   ) ETHNICITY: ____

LIST ALLERGIES: ____

HEALTH CONSIDERATIONS: ____

LIST MEDICATIONS ADMINSTERED AT SCHOOL: ____

GLASSES YES (   ) NO (   ) HEARING AIDS YES (   ) NO (   ) ASTHMA YES (   ) NO (   ) DIABETES YES (   ) NO (   )

STUDENT'S NAME: ____DOB_______________GRADE________

BOY (   ) GIRL (   ) ETHNICITY: ____

LIST ALLERGIES: ____

HEALTH CONSIDERATIONS: ____

LIST MEDICATIONS ADMINSTERED AT SCHOOL: ____

GLASSES YES (   ) NO (   ) HEARING AIDS YES (   ) NO (   ) ASTHMA YES (   ) NO (   ) DIABETES YES (   ) NO (   )

STUDENT'S NAME: ____DOB_______________GRADE_______

BOY (   ) GIRL (   ) ETHNICITY: ____

LIST ALLERGIES: ____

HEALTH CONSIDERATIONS: ____

LIST MEDICATIONS ADMINSTERED AT SCHOOL: ____

GLASSES YES (   ) NO (   ) HEARING AIDS YES (   ) NO (   ) ASTHMA YES (   ) NO (   ) DIABETES YES (   ) NO (   )

STUDENT'S NAME: ____DOB_______________GRADE_______

BOY (   ) GIRL (   ) ETHNICITY: ____

LIST ALLERGIES: ____

HEALTH CONSIDERATIONS: ____

LIST MEDICATIONS ADMINSTERED AT SCHOOL: ____

GLASSES YES (   ) NO (   ) HEARING AIDS YES (   ) NO (   ) ASTHMA YES (   ) NO (   ) DIABETES YES (   ) NO (   )

If deemed necessary, your child will be sent to your family doctor or emergency room at parent/guardian's expense. As a parent/guardian, I authorize medical personnel to render necessary medical treatment to my child. I give consent to release this information to St. Paul's Lutheran-Cudahy, WI , personnel to promote the health and safety of my child, thus enhancing their ability to learn.

Signature required: ____*date*____________________

The above signature acknowledges that I have read and consent to the above.