



2018-2019 APPLICATION & MEDICAL INFORMATION

Name _____

Last

First

Middle

Gender ___ Grade 2018/19 ___ Birth Date ___/___/___

Street Address _____ City _____ Zip _____ Home # _____

Last School Attended _____ Religious Affiliation Parishioner Catholic; Non-Parishioner Non-Catholic

Please indicate who has legal custody by checking the following box/es: Church of Affiliation _____

Mother's Name _____ Home # _____ Cell # _____

Street Address _____ City _____ Zip _____

Workplace _____ Work # _____ Email _____

Father's Name _____ Home # _____ Cell # _____

Street Address _____ City _____ Zip _____

Workplace _____ Work # _____ Email _____

Guardian's Name _____ Home # _____ Cell # _____

Street Address _____ City _____ Zip _____

Workplace _____ Work # _____ Email _____

With whom does the child live? Father Mother Guardian Other Adults in home _____

Please list any physical limitations or medical problems

Circle all that apply: Asthma y / n Seizures y / n

Allergies y / n If yes, please list and explain

With whom (other than legal guardians) may your child be released?

Name _____ Phone # _____

Name _____ Phone # _____

What is your child's typical mode of transportation after school?

Car Rider Walker Bike Rider Extended Care

*Please note that a 2018-19 permission form must be on file.

In case of emergency when parents cannot be located, please list in order of preference who we should contact LOCALLY:

Name _____ Name _____

Relationship to child _____ Relationship to child _____

Home # _____ Home # _____

Work # _____ Work # _____

In case of an emergency involving your child, it is the policy of Holy Name Catholic School to render first aid treatment while contacting parents/guardians for further instructions. In the event that the parents/guardians cannot be contacted, school officials will contact 911.

I grant permission to Holy Name Catholic School personnel to send my child to the hospital for treatment. My hospital preference is _____.

I give the Holy Name Catholic School Personnel authorization to treat my child in the absence of the school nurse.

Insurance coverage: y / n _____

Parent/Guardian Signature _____

Date _____