School _____ **REGISTRATION AND MEDICAL EMERGENCY FORM** Grade: K 1 2 3 (circle one)

Greenfield-Central Community School Corporation (3/10/2014)

Student Name _____ (_____) Date of Birth _____-_____ -_____ Male ____ Female _____
Last First Middle Prefers to be called

Address _____ Primary # _____-_____-_____
Number & Street Apt. # City & State Zip Code

Child lives with: Father_____ Mother_____ Step-Parent _____ Grandparent_____ Other (List) _____

Father's Name: _____ Mother's Name: _____

Please check one of the following that most accurately describes the student's racial or ethnic background:

____ Caucasian ____ American Indian/Alaskan Native ____African-American ____ Asian ____ Hispanic ____ Multiracial ____Other_____

CONTACT INFORMATION: List in order, those persons to be called in case of an emergency, such as Mother, Father, Relatives, Caregiver, Friends, Neighbors:

1st Person to Call – Full Name	Relationship to Child	Daytime Phone #	Cell Phone #	E-mail Address
2nd Person to Call – Full Name	Relationship to Child	Daytime Phone #	Cell Phone #	E-mail Address
3rd Person to Call – Full Name	Relationship to Child	Daytime Phone #	Cell Phone #	E-mail Address

MEDICAL INFORMATION

My child is ALLERGIC to: *Bee Sting_____ *Medication_____ *Food_____ *Other_____ *If you check any item, give details below:
_____

My child has a MEDICAL CONDITION: *Asthma_____ *Diabetes_____ *Seizures_____ *ADD/ADHD_____ *Other_____ *Give details below:
_____

List any prescribed medications: _____

DOCTOR'S NAME: _____ Phone # _____ DENTIST'S NAME: _____ Phone # _____

HOSPITAL: 1ST Choice: _____ 2nd Choice: _____

******In case of an emergency, and I or a member of my family cannot be contacted, I give my permission for the school authorities to seek medical treatment for my child, and I assume responsibility for such emergency expenses.******

Signature of Parent/Guardian: _____ Date: _____