

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:

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