

Contact information

Studen	t Name:									
Date of Birth:					Age:		Sex:	M or F	M or F	
Child's Primary A	ddress:									
Custody : (circle one)	Both	Mother	Father	Other:	(Please List)					
Mother's Legal Nan	ne/Legal G	iuardian 1:					Address same	as above:	Y or N	
Cell #:		_Work #:			_	Employer:				
Home Address: (if different)					_ Work	Address:				
Father's Legal Nam							Address same	as above:	Y or N	
Cell #:		_Work #:			_	Employer:				
Home Address: (if different)					_ Work	Address:				
<u>lf a</u>	parent or	guardian ca	annot be r	eached ir	n an emer <u>c</u>	gency, then	please notify	<u>y:</u>		
Name:				Relat	ionship:					
 Cell #:				-	Work#:					
Home Address:				-	_ Work	Address:				
Name:				Relat	– ionship:					
Cell #:				_	Work#:					
Home Address:					_ Work	Address:				
					_		Continue to	 o pg.2		

Health History

List name and dosage of any medication t	taken on a	regular	basis:				
List any allergies to medication:							
List any other allergies:							
Please specify if the student is under any	special me	edical tre	atment or diet:				
Any activity restrictions? No	Or Circle One	Yes	If yes, please list:				
Date of last tetanus Shot:	Circle Offe		Wears contact lenses: Yes or No Circle One				
Check if any of the following co	onditions a	ire prese	nt:				
Hay fever Allergic to insects			Heart condtion Diabetes				
Frequent stomach up Epilepsy/nervous dis Hearing/vision loss	•	Asthma Any major illness/surgery in the past Food allergies					
If any of the above are checked, please gi	ve details:						
				<u> </u>			
representative to hospitalize and/or secure pr	oper medica nents, includ	al treatmer ing surger	sion to the physician selected by St. Ann Catholic School or its nt for the above named student. I understand that I am y, received by my child. I understand that I will be contated	1			
Signature:			Date:				
Insurance Company:			Phone #:				
Policy #:			Group #·				