ORTING School District #344

Student Information

Student Legal Last Name_____ **Student Legal** First Name _____

Student Legal Middle_____ Birthdate (Mth/Day/Yr)_____ Grade_____ Gender ☐ Male ☐ Female

Household #1 - Parent/Guardian #1

Last Name_____ First Name_____ Cell Phone (_____) _____

Relationship to Student ☐ Father ☐ Mother ☐ Guardian ☐ Foster ☐ Other_____ Home Phone (_____) _____

Please check if unlisted ☐

Employer:_____ Work Phone (_____) _____ Ext: _____

Primary contact phone number (check one) ☐ home ☐ cell ☐ work e-mail _____

Street Address_____ Apt#_____ City, State, ZIP Code _____

Mailing Address/PO Box_____ City, State, ZIP Code _____

(Complete if different than street address)

Household #1 - Parent/Guardian #2

Last Name_____ First Name_____ Cell Phone (_____) _____

Relationship to Student ☐ Father ☐ Stepfather ☐ Mother ☐ Stepmother ☐ Guardian ☐ Foster ☐ Other_____

e-mail _____

Employer:_____ Work Phone (_____) _____ Ext: _____

Household #2 – See next page.

Authorization and Consent/Child Release

To ensure children's safety, Sumner School District will release a child only to the parent(s)/legal guardians who have signed this form and to those listed below as undersigned by the parent/guardian.

Name:_____ Relationship: _____

Day Ph.:_____ Cell Ph.:_____ Evening Ph.:_____

Name:_____ Relationship: _____

Day Ph.:_____ Cell Ph.:_____ Evening Ph.:_____

Name:_____ Relationship: _____

Day Ph.:_____ Cell Ph.:_____ Evening Ph.:_____

Out of State Contact

Name:_____ Relationship:_____ Ph.:_____

Address:_____ City:_____ St:_____ Zip:_____

Health/Physician Information

Physician Name:_____ Phone: _____

Address:_____ City,State,Zip: _____

Child's Weight:_____ Height:_____ Eye Color:_____ Hair Color: _____

Medications Taken Regularly: _____

_____ Frequency:_____

_____ Reason: _____ Other Medical

Conditions to be aware of: _____ Date of last physical:_____

_____ Allergies: _____ Dentist Name:_____

_____ Phone: _____ Address:_____

_____ City,State,Zip: ____ Insurance Coverage:_____

_____ Member/policy number: _____

Policy Holder Name:_____ Employer Name: _____

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. If I cannot be reached, I understand that the emergency contacts listed will be called. I understand the faculty in the child care center is trained in the basics of first aid and CPR and authorize them to give either to my child as necessary.

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

By signing I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/Guardian Signature:_____ Date: _____

Original signature required.