

**St. Michael's Episcopal Day School Student Registration and Emergency  
2011-2012 School Year**

<b>STUDENT #1 INFORMATION</b>			
Grade	Date of Birth / /	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Student Last Name	First Name	Middle Name	
PLEASE CHECK THE FOLLOWING ITEMS IF THEY PERTAIN TO YOUR CHILD.			
Check here if there are <b>NO KNOWN</b> health problems <input type="checkbox"/>		Allergies _____ Allergic reaction/bee stings <input type="checkbox"/>	
<b>GENERAL HEALTH</b>		Asthma _____	
Has the following condition (s):		Are any of the above life threatening? _____	
Seizure Disorder <input type="checkbox"/>	Migraines <input type="checkbox"/>	List medication prescribed: _____	
Diabetes <input type="checkbox"/>	Heart Condition <input type="checkbox"/>	Has a physical condition which limits participation in: classroom activities _____ physical education _____	
Fainting spells <input type="checkbox"/>		Please explain _____	

<b>Parent Information</b>			
Mother or Guardian	Home Address	Home Phone	
	City	Zip	
Business Name	Pager	Business Phone	
Business Address/Zip	Cell Phone	E-Mail	
Father or Guardian	Home Address	Home Phone	
	City	Zip	
Business Name	Pager	Business Phone	
Business Address/Zip	Cell Phone	E-Mail	

**If the school cannot contact parent, name a relative or friend who may be called if the child is ill.**

Relative or Friend	Address	Phone
Relative or Friend	Address	Phone
Physican	Address	Phone
Medical Insurance Co.	I.D. Number	Hospital Preference

<b>Medical Treatment Authorization</b>
In the event of an accident or other emergency, when a parent is unavailable, I hereby authorize a representative of the school to make such arrangements as considered necessary for my child to receive medical or hospital care, including necessary transportation. Under such circumstances, I further authorize the physician named above to undertake such care and treatment of my child as necessary. In the event said physician is not available at the time, I authorize such care and treatment to be performed by any licensed physician or surgeon.
<b>SIGNATURE</b>
I give my permission for authorized staff of St. Michael's Episcopal Day School to administer Tylenol according to the age prescribed dose.
<b>SIGNATURE</b>

<b>School Activities Authorization</b>
I give my permission for my child to participate in all activities which are part of the school program, including field trips and excursions away from school premises, and inclusion in marketing materials including web site, publications and videos, and hold the school not responsible for accidents or injuries not directly related to its own negligence.
Date _____ Signature _____

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<b>STUDENT #2 INFORMATION</b>			
Grade	Date of Birth / /	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Student Last Name	First Name	Middle Name	
PLEASE CHECK THE FOLLOWING ITEMS IF THEY PERTAIN TO YOUR CHILD.			
Check here if there are <b>NO KNOWN</b> health problems <input type="checkbox"/>		Allergies _____ Allergic reaction/bee stings <input type="checkbox"/>	
<b>GENERAL HEALTH</b>		Asthma _____	
Has the following condition (s):		Are any of the above life threatening? _____	
Seizure Disorder <input type="checkbox"/>	Migraines <input type="checkbox"/>	List medication prescribed: _____	
Diabetes <input type="checkbox"/>	Heart Condition <input type="checkbox"/>	_____	
Fainting spells <input type="checkbox"/>		Has a physical condition which limits participation in: classroom activities _____ physical education _____	
		Please explain _____	

<b>STUDENT #3 INFORMATION</b>			
Grade	Date of Birth / /	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Student Last Name	First Name	Middle Name	
PLEASE CHECK THE FOLLOWING ITEMS IF THEY PERTAIN TO YOUR CHILD.			
Check here if there are <b>NO KNOWN</b> health problems <input type="checkbox"/>		Allergies _____ Allergic reaction/bee stings <input type="checkbox"/>	
<b>GENERAL HEALTH</b>		Asthma _____	
Has the following condition (s):		Are any of the above life threatening? _____	
Seizure Disorder <input type="checkbox"/>	Migraines <input type="checkbox"/>	List medication prescribed: _____	
Diabetes <input type="checkbox"/>	Heart Condition <input type="checkbox"/>	_____	
Fainting spells <input type="checkbox"/>		Has a physical condition which limits participation in: classroom activities _____ physical education _____	
		Please explain _____	

<b>STUDENT #4 INFORMATION</b>			
Grade	Date of Birth / /	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Student Last Name	First Name	Middle Name	
PLEASE CHECK THE FOLLOWING ITEMS IF THEY PERTAIN TO YOUR CHILD.			
Check here if there are <b>NO KNOWN</b> health problems <input type="checkbox"/>		Allergies _____ Allergic reaction/bee stings <input type="checkbox"/>	
<b>GENERAL HEALTH</b>		Asthma _____	
Has the following condition (s):		Are any of the above life threatening? _____	
Seizure Disorder <input type="checkbox"/>	Migraines <input type="checkbox"/>	List medication prescribed: _____	
Diabetes <input type="checkbox"/>	Heart Condition <input type="checkbox"/>	_____	
Fainting spells <input type="checkbox"/>		Has a physical condition which limits participation in: classroom activities _____ physical education _____	
		Please explain _____	