



PLEASE MAKE CORRECTIONS AND/OR FILL IN AREAS LEFT BLANK AND RETURN TO THE SCHOOL OFFICE BY THE FIRST DAY OF CLASSES. THANK YOU.

Student Last Name	Student First Name	Student Middle Name/MI	Grade in 2019-2020
Street	City	State	Zip
Parent 2 Address	City	State	Zip
Date of Birth	Gender	Home Phone	
Student Lives With	Guardian (if applicable)	Date of Birth	
Religion	Parish	Race (used to provide information for yearly state statistical reports)	

FATHER'S INFORMATION

Father's Name	Father's Home Phone	Father's Mobile Phone
Father's Email Address	Father's Work Phone	
Father's Occupation	Father's Employer	Father's Work Address

MOTHER'S INFORMATION

Mother's Name	Mother's Home Phone	Mother's Mobile Phone
Mother's Email	Mother's Work Phone	
Mother's Occupation	Mother's Employer	Mother's Work Address

Please indicate if we should be providing information to a parent other than the one with whom the student is living:

List two available neighbors/relatives who could assume temporary care of your son/daughter should be unavailable. Must be available during school hours.

Name	Relationship	Phone
Name	Relationship	Phone

PLEASE TURN OVER →

Are there any individuals who are restricted from picking up your son/daughter? YES NO (Legal documentation required)

Name of individual Relationship to child

Is there a court ordered restraining order? YES NO (Legal documentation required)

Official Parent Signature

HEALTH INFORMATION

Health Update for:

Grade:

If allergies exist, please describe specific allergic reaction:

Allergies:

Vision Problems:

Glasses?

Contacts?

Hearing Problems:

Illness, injuries, concussions, or surgery since last year? _____ If yes, please describe. (Please use a separate piece of paper if needed.)

MEDICATION INFORMATION

Please note that no medicine of any type (aspirin, Motrin, Tylenol, vitamins, and the like) can be taken without written authorization. No student may have any medicine in his/her possession at any time. *Only exception, nurses give inhalers to students on field trips.

Please refer to medication administration policy in the *JPII Parent Student Handbook*. Medication/prescription order forms from your child's physician are needed for any medication given to students at school.

List medications taken on a regular basis, dosage, and time taken and reason that the medication is taken (Please use a separate piece of paper if needed.)

Medication	Dose	Time taken	Reason for medication

I give permission for Motrin and/or Tylenol to be given, as needed: YES NO (Please circle one)

Is there additional information of which the Health Clinic should be aware? If yes, please explain:

Name of Physician

Phone:

Date of Last Physical Exam(Please supply a copy)

Additional Information Per Department of Public Health:

Student must have a documented physical exam on file by Grade 9.

Student must have a complete Record of Immunization on file at St. John Paul II High School.

I understand that in the event of an accident or serious illness the school will try to contact me. If the school is unable to reach me, I authorize the school to contact the physician named and to follow his/her instructions. If the physician cannot be reached and my child requires medical attention and/or transportation to another location for treatment, I give the school permission to make arrangements deemed necessary to secure treatment.

I hereby certify that I have read and understand the above stated procedures and duly authorize the administration of the school and/or school nurse to secure medical treatment and/or transport my child when they deem it necessary and share pertinent medical information with the school staff for the benefit of my child.

Parent(s) signature

Date