**SETON FOUNDATION FOR LEARNING**

**PLEASE PRINT**

FAMILY LAST NAME: _____

CHILD FIRST NAME: _____ DATE OF BIRTH _____

HOME ADDRESS: _____ HOME PHONE_____

CITY, STATE, ZIP _____

FATHER'S/GUARDIAN'S FULL NAME_____

WORK PHONE_____ CELL PHONE_____ EMAIL_____

MOTHER'S/GUARDIAN'S FULL NAME_____

WORK PHONE_____ CELL PHONE_____ EMAIL_____

**OTHER ADULTS AUTHORIZED TO PICK UP**

NAME:_____ RELATIONSHIP_____ CELL PHONE_____

NAME:_____ RELATIONSHIP_____ CELL PHONE_____

NAME:_____ RELATIONSHIP_____ CELL PHONE_____

IN THE EVENT OF EMERGENCY, WHO WOULD BE AVAILABLE TO PICK UP CHILD (WITHIN 15 MINUTES)?_____

* Any person unfamiliar to staff will be required to show identification. Under NO circumstances will the student be releases to anyone other than those listed without WRITTEN permission.

DOCTOR:_____ DOCTOR PHONE NUMBER:_____

MEDICAL CONCERNS:_____

ALLERGIES:_____

MEDICATION TAKEN REGULARLY:_____

IN THE EVENT THAT A STUDENT REQUIRES EMERGENCY OR MEDICAL TREATMENT EVERY ATTEMPT WILL BE MADE TO CONTACT THE PARENT/GUARDIAN HOWEVER I AUTHORIZE ANY AND ALL EMERGENCY MEDICAL, DENTAL AND/OR SURGICAL CARE AND HOSPITALIZATION ADVISED BY THE PHYSICIANS, SURGEON OR HOSPITAL NECESSARY FOR THE PROPER HEALTH AND WELL-BEING OF MY CHILD.

PREFERRED HOSPITAL:_____

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____