PLEASE FILL OUT THE FOLLOWING INFORMATION AS COMPLETE AS POSSIBLE.

STUDENT'S NAME _____
First Middle Last

DATE OF BIRTH _____

PARENTS NAME _____

PHYSICAL ADDRESS _____

MAILING ADDRESS _____

CITY_____

STATE _____ ZIP _____

COUNTY _____

HOME PHONE_____CELL PHONE _____WORK PHONE _____

DOCTOR'S NAME _____

MEDICAL COMMENTS_____

E-MAIL ADDRESS _____

RACE (OPTIONAL):

_____WHITE
_____AMERICAN INDIAN
_____HISPANIC
_____OTHER
_____ASIAN
_____NATIVE HAWAIIAN OR PACIFIC ISLANDER
_____BLACK OR AFRICAN AMERICAN

If we are unable to contact you and your child is sick, hurt or there is a weather related emergency, this person has permission to pick up your child.

Name _____
First Last

Relationship_____

Home phone number _____

Work phone number _____

Cell phone number _____

Second contact person—this is the person you would like us to contact if we can't reach the first person listed.

Name _____
First Last

Relationship _____

Home phone number _____

Work phone number _____

Cell phone number _____

PLEASE READ CAREFULLY AND SIGN <u>EITHER</u> OPTION A OR B (SIGN ONLY ONE OPTION)

A. I GIVE MY PERMISSION TO AUTHORIZE EMERGENCY MEDICAL TREATMENT TO MY CHILD IF EITHER PARENT OR THE PERSON LISTED ABOVE TO BE CALLED IN AN EMERGENCY, CAN NOT BE REACHED.

SIGNATURE OF PARENT _____ DATE _____

B. I DECLINE TO GIVE PERMISSION FOR EMERGENCY MEDICAL TREATMENT FOR MY CHILD.

SIGNATURE OF PARENT _____ DATE _____

I FURTHER CERTIFY THAT I WILL NOT HOLD LIABLE ANY OFFICIAL OF THE PENDER PUBLIC SCHOOL SYSTEM FOR COMPLICATIONS THAT MAY RESULT FROM MY RELUCTANCE TO GRANT EMERGENCY TREATMENT AUTHORIZATION FOR MY CHILD.

SIGNATURE OF PARENT _____ DATE _____