Emergency Numbers *(Please use local phone numbers of people who can pick up your child and be responsible for them.)*

1. _____

Name *Relationship* *Home Phone #* *Work Phone #* *Cell Phone #*

2. _____

Name *Relationship* *Home Phone #* *Work Phone #* *Cell Phone #*

3. _____

Name *Relationship* *Home Phone #* *Work Phone #* *Cell Phone #*

Medical

Please list medical conditions or allergies that Twin Ridges Elementary School District should be aware of and make necessary explanations**.**

_____

_____

_____

Please list any medications taken on a regular basis and an explanation.

_____

Do these medications need to be taken at school? ☐ **Yes** ☐ **No**

Administration of medication at school form on file? ☐ **Yes** ☐ **No**

Military

Is a parent or guardian in your household a member of the Armed Forces on active duty or on full time National Guard duty**?** ☐ **Yes** ☐ **No**

RESIDENCE

Where is your child/family currently living? Federally mandated by No Child Left Behind Act.

Please check appropriate box:

- ❑ In a single family permanent residence (house, apartment, condo, mobile home)
- ❑ Doubled-up (sharing housing with other families/individuals due to economic hardship or loss)
- ❑ In a shelter or transitional housing program
- ❑ In a motel/hotel
- ❑ Unsheltered (car/campsite)
- ❑ Single family foster family home or kinship
- ❑ Other (please specify)_____

Health Information *(Please check if your child has had, or now has, any of the following medical conditions.)*

☐ Chicken Pox	☐ Measles (10-day)	☐ Poliomyelitis	☐ Strep Throat	☐ Meningitis
☐ Diphtheria	☐ Mumps	☐ Reyes Syndrome	☐ Tonsils/Adenoids Removal	☐ Epilepsy
☐ Hepatitis B	☐ Physical Handicap	☐ Rheumatic Fever	☐ Tuberculosis Contact	☐ Diabetes
☐ Measles (3-day)	☐ Pneumonia	☐ Scarlet Fever	☐ Whooping Cough	☐ Other:

Emergency Treatment Release

In case of accident or other emergency, **<u>if a parent or guardian cannot be reached</u>**, I hereby authorize a representative of the school to make such arrangements, as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation. Under such circumstances, I further authorize the physician named below to undertake such care and treatment of my child as he/she considers necessary. In the event said doctor is not available, I authorize such care and treatment to be performed by any licensed physician or surgeon.

I understand that the Twin Ridges Elementary School District does not provide medical or accident insurance for students for school-related injuries or treatment. The undersigned hereby agrees to bear all costs incurred as a result of the foregoing.

Any amendments or deletions on this authorization should be initialed by the parent/guardian. This authorization will remain in effect until revoked by the undersigned.

Physician _____Phone #_____

Insurance Company_____

Insurance ID Number _____

Group Number _____

I hereby certify that all information entered on this enrollment form is true and correct. I also understand and agree to the above Emergency Treatment Release.

_____ _____

Signature of Parent/Legal Guardian **Date**