

Guardian Angels Student Information Form



FAMILY LAST NAME: _____

Child/ren's Name(s): _____

EMERGENCY/SPECIAL NEEDS INFORMATION:

If we are unable to reach you, whom should we contact?

Name: _____ Relationship: _____ Phone Number(s): _____

Health Insurance Co: _____ Policy/Group Number: _____

Person responsible for charges: _____ Hospital Name: _____

Physician's Name: _____ Clinic Name: _____ Phone Number: _____

For the following, please list your child/ren's name and any special conditions:

Allergies (including medications): _____

Prescribed Medication and/or over the counter medications: _____

Any special learning needs (e.g., ADHD, certain learning accommodations) or special home conditions (e.g., recent divorce, military deployment, new siblings) or any other special situations that you feel will help us better serve your child/ren: _____

CONSENT FOR MEDICAL CARE:

I give permission that in my absence (list child/ren's name/s), _____, may receive emergency medical care for injuries and all situations that should occur while participating in programs at Guardian Angels Catholic Church.

Signed (Parent/Guardian): _____ Date: _____

VOLUNTEERING WITH CHRISTIAN EDUCATION

Our programs only work with the help of parents. Please let us know which area you may wish to be involved with:

- | | | | |
|------------------|---------------------|----------------------|---------------------|
| _____ Teaching | _____ Youth Group | _____ Special Events | _____ Childcare |
| _____ Substitute | _____ Classroom Aid | _____ Hall Monitor | _____ Clerical Help |