Student's name _____

Grade _____ Date of birth _____ Gender _____

Parent / Guardian's name _____

Home address _____

Home phone _____ Cell phone _____ Work phone _____

Family doctor _____ Phone _____

Address _____City_____ State____

Family dentist _____ Phone _____

Address _____City_____ State____

Hospital of choice _____

Family Health Plan Carrier _____ Policy # _____

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend St Joseph Mission School, its officers, directors, employees and agents, and the Diocese of Gallup, its employees and agents, from any claim arising from or in connection with my child attending the school or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish/school, its officers, directors and agents, and the Diocese of Gallup, its employees and agents representative associated with the school for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/school or the Diocese of Gallup.

Signature: _____ Date: _____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health and I assume all responsibility for the health of my child.

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact one of the following emergency contacts:

Name & relationship: _____

Phone Numbers: _____

Name & relationship: _____

Phone Numbers: _____

Signature: _____ Date: _____

Medications: My child is taking medication at present. My child will bring all such medications necessary and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

_____

_____

_____

Signature: _____Date: _____

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Signature: _____Date: _____

I hereby grant permission for non-prescription medication (i.e. non-aspirin products such as acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____Date: _____