

## CONTACTS, MEDICAL, AND AUTHORIZATIONS

### EMERGENCY INFORMATION

**For office use:**

- Date received \_\_\_\_\_
- Entered in RenWeb

**Students' Names:**

\_\_\_\_\_  
LAST FIRST

\_\_\_\_\_  
LAST FIRST

\_\_\_\_\_  
LAST FIRST

\_\_\_\_\_  
LAST FIRST

\_\_\_\_\_  
LAST FIRST

\_\_\_\_\_  
LAST FIRST

**Parents' Information:**

\_\_\_\_\_  
LAST FIRST

\_\_\_\_\_  
LAST FIRST

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
ADDRESS  (Check if the same as first parent)

\_\_\_\_\_  
CITY STATE ZIP

\_\_\_\_\_  
CITY STATE ZIP

\_\_\_\_\_  
HOME PHONE CELL PHONE WORK PHONE

\_\_\_\_\_  
HOME PHONE CELL PHONE WORK PHONE

**Please list two persons to notify in case of an emergency if parents cannot be reached:**

\_\_\_\_\_  
NAME

\_\_\_\_\_  
NAME

\_\_\_\_\_  
HOME PHONE CELL PHONE WORK PHONE

\_\_\_\_\_  
HOME PHONE CELL PHONE WORK PHONE

\_\_\_\_\_  
RELATIONSHIP TO THE STUDENT

\_\_\_\_\_  
RELATIONSHIP TO THE STUDENT

**Doctor's information:**

\_\_\_\_\_  
NAME

\_\_\_\_\_  
PHONE NUMBER

### MEDIA RELEASE (required)

Because we frequently video or photograph our student body, we require all parents to sign this release as a condition of enrollment.

I hereby grant permission to The Ambrose School, or its designees, to publish photographs and/or videos of my child(ren).

- My child(ren) *may* be interviewed.
- My child(ren) *may not* be interviewed.

\_\_\_\_\_  
SIGNATURE OF PARENT DATE

\_\_\_\_\_  
SIGNATURE OF PARENT DATE

**Please fill out other side.**

# GRANDPARENT INFORMATION

List grandparents who would like to be informed about what is happening at The Ambrose School.

---

LAST FIRST

---

ADDRESS

---

CITY STATE ZIP

---

HOME PHONE CELL PHONE WORK PHONE

---

EMAIL ADDRESS

---

LAST FIRST

---

ADDRESS

---

CITY STATE ZIP

---

HOME PHONE CELL PHONE WORK PHONE

---

EMAIL ADDRESS

---

LAST FIRST

---

ADDRESS

---

CITY STATE ZIP

---

HOME PHONE CELL PHONE WORK PHONE

---

EMAIL ADDRESS

---

LAST FIRST

---

ADDRESS

---

CITY STATE ZIP

---

HOME PHONE CELL PHONE WORK PHONE

---

EMAIL ADDRESS

---

LAST FIRST

---

ADDRESS

---

CITY STATE ZIP

---

HOME PHONE CELL PHONE WORK PHONE

---

EMAIL ADDRESS

---

LAST FIRST

---

ADDRESS

---

CITY STATE ZIP

---

HOME PHONE CELL PHONE WORK PHONE

---

EMAIL ADDRESS

# OTHER FAMILY AND FRIENDS INFORMATION

List family and friends who you think might be interested in events at The Ambrose School.

---

LAST FIRST

---

ADDRESS

---

CITY STATE ZIP

---

HOME PHONE EMAIL ADDRESS

---

RELATIONSHIP TO THE STUDENT

---

LAST FIRST

---

ADDRESS

---

CITY STATE ZIP

---

HOME PHONE EMAIL ADDRESS

---

RELATIONSHIP TO THE STUDENT

## CUSTODIAL PARENT RELEASE (required)

By signing below, I affirm that I am legally able to transport my child(ren) to and from school.

\_\_\_\_\_  
SIGNATURE OF PARENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT

\_\_\_\_\_  
DATE

## K- 6<sup>th</sup> GRADE DISMISSAL RELEASE

7<sup>th</sup> -12<sup>th</sup> grade students are released on their own recognizance.

I hereby authorize The Ambrose School to release my child(ren) for dismissal according to the following process:

Each student will be issued three cards: a white card, a yellow card and a green card. On each card, you will write a primary contact number on the front and authorized pick up drivers on the back. These cards will attach to the top of your students' backpacks. Each morning, you will clip on to your student's backpack the card which tells us by its color which line the student will be standing in for pick up, or if he or she is in an after school program or activity. Tags and complete instructions will be issued in the summer packet or upon admission.

\_\_\_\_\_  
SIGNATURE OF PARENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT

\_\_\_\_\_  
DATE

## DISCIPLINE RELEASE

I hereby grant permission to administer corporal punishment (spanking) according to the stated policy below.

I do not want my child spanked by The Ambrose School.

Spanking will only be administered with the consent of the parents. If the Administrator determines that a spanking is necessary, he will attempt to contact one of the child's parents before the spanking is administered. When the parent cannot immediately respond, the Administrator will explain the nature of the offense to the child. The spanking will be done with another adult witness present in the Administrator's office. At least one of the adults shall be female if the child is female. Spanking will be limited to three (3) swats with a paddle on the buttocks, followed by reassurance and prayer. The child will be allowed to compose himself before reentering the classroom. As in all discipline situations, the Administrator acts in *loco parentis*, on behalf of the parents.

\_\_\_\_\_  
SIGNATURE OF PARENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT

\_\_\_\_\_  
DATE

## HANDBOOK POLICIES AGREEMENT (required)

I agree to abide by the policies set in parent handbook.

\_\_\_\_\_  
SIGNATURE OF PARENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT

\_\_\_\_\_  
DATE

**Please fill out other side.**

## MEDICAL RELEASE

Hospitals may be reluctant to treat or care for children without consent from parents or guardians. This can cause delay in treatment if there is a medical emergency when parents or guardians are not available to give consent. In case of emergency, this form will be taken with the child(ren) listed on the first page to the hospital.

I, \_\_\_\_\_, the natural parent/legal guardian of (list all children) \_\_\_\_\_, authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when, in the sole discretion of the attending physician, such care, treatment and procedures are immediately necessary or advisable in the interest of my child's health and well-being, after the school has made every effort to contact me.

Under the circumstances set forth above, I elect not to be informed in advance of the nature and character of the proposed treatment, its anticipated results and possible alternatives, and the risks, complications and anticipated benefits involved in the proposed treatment and the alternative forms of treatment, including non-treatment.

\_\_\_\_\_  
SIGNATURE OF FATHER / GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF MOTHER / GUARDIAN

\_\_\_\_\_  
DATE

## HEALTH HISTORY

1. Please check the illnesses below that your child(ren) has/have experienced:

	CHILD'S NAME	CHILD'S NAME	CHILD'S NAME	CHILD'S NAME	CHILD'S NAME
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
German Measles (Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard Measles (Rubeola)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please explain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Is/Are your child(ren) taking any medication regularly? Please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Does/Do your child(ren) have hearing or vision problems? Please explain:

\_\_\_\_\_  
\_\_\_\_\_

4. Has/Have your child(ren) had any physical problems, surgeries, disabilities, asthma, hay fever, or other serious illnesses not listed above? Please explain:

\_\_\_\_\_  
\_\_\_\_\_

5. Does/Do your child(ren) have a serious allergy to certain foods or insect bites?

\_\_\_\_\_  
\_\_\_\_\_

6. Does/Do your child(ren) have a severe reaction to medicine, prescription drugs or antibiotics?

\_\_\_\_\_  
\_\_\_\_\_