5307.A.1-3.

Student Master Card

Child's Name:______________________________ Sex:_____ Birth date:____________________

	Mother	Father
Name		
Address		
Employer		
Home Phone #		
Work Phone #		
Cellular Phone #		
Email Address		

Person with whom the child lives:______________________________
Child's Doctor:____________________ Doctor's Phone #:____________________
Child's Dentist:____________________ Dentist's Phone #:____________________

Individuals to contact in case of emergency:

______________________________ Phone #:____________________
______________________________ Phone #:____________________
______________________________ Phone #:____________________
______________________________ Phone #:____________________

Does your child have any food allergies? Yes ❑ No ❑
Does your child have any other allergies? Yes ❑ No ❑
Does your child have any dietary restrictions? Yes ❑ No ❑
Please explain any "yes" answer here:______________________________

My child has permission to be released to the following individuals, child care facilities or transportation services in addition to emergency contact persons listed above.
(Please notify these individuals that they may be asked to show proof of identity)

Name	Relationship

I authorize the facility to secure emergency medical treatment for my child.

Parent's Signature:______________________________ Date:________________

Date of admission:______________________________