

Please Print Clearly.

**Registration/Emergency Medical Form
Oregon City Schools**

Resident School: _____ Date: _____ 06-07 Grade _____

Assigned School: _____

Student's Legal Name: _____ (_____)

_____ Last First Middle Preferred Name or Nick Name
_____ Check if new address Has this child ever attend the Oregon City Schools? YES NO

Address: _____ City: _____ Zip Code: _____

Between What Crossroads: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Birthdate: _____ Age _____ Social Security No.: _____

Birth City: _____ Mother's Maiden Name: _____

Gender: _____ Male _____ Female Ethnicity: _____ Caucasian _____ African American _____ Hispanic
_____ Asian _____ American Indian _____ Multiracial

Native Language if other than English _____

Please indicate custodial parent:

_____ Mother & Father _____ Mother _____ Father _____ Guardian

Please indicate anyone who is NOT PERMITTED to visit/pick up your student from school:

Name of Person(s) With Whom the Child Resides:

Name: _____ Relationship to Child: _____

Place of Employment: _____ Work Phone: _____

Cell Phone: _____

Name: _____ Relationship to Child: _____

Place of Employment: _____ Work Phone: _____

Cell Phone: _____

Emergency Phone Number of person other than the parents/guardians if they cannot be reached at home or work:

1. Name and Relationship to Child: _____

Phone No.: _____

2. Name and Relationship to Child: _____

Phone No.: _____

If babysitter, Y Program, or daycare please list:

Name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Cell _____

(OVER)

Please Print Clearly.

Child's Prior Experience: _____ Child Care Center _____ Head Start _____ Preschool in public school
_____ Preschool NOT in a public school _____ Special Education Service Provided

Name of Preschool _____
AM Only _____ PM Only _____ AM and PM _____

Does the child have any health problems? _____

Does your child need medication administered at school? _____ If so, you will need to complete a *Dispensing of Medication* form at the home school.

I give permission for _____'s health information to be shared with school staff and emergency care personnel as needed. _____ Yes _____ No

Parent/Guardian Signature _____ Date _____

Part I: TO GRANT CONSENT (This form used on all field trips)

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies; medications being taken, and any physical impairments to which a physician should be alerted:

Date _____ Signature of Parent/Guardian _____
Address _____
City _____ Zip _____

PART II: REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Date _____ Signature of Parent/Guardian _____
Address _____
City _____ Zip _____