

Student Registration/Information Record – 2024/25

\_\_\_\_Our family is a member of this parish (Currie, Milroy, Tracy).

1. Name of student: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
  First                      Last                      Middle
2. Parents-Mother: \_\_\_\_\_  
Address: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Mother's Phone Work: \_\_\_\_\_ Cell: \_\_\_\_\_
3. Parents-Father: \_\_\_\_\_  
Address: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Father's Phone Work: \_\_\_\_\_ Cell: \_\_\_\_\_
4. Name of family physician and dentist:  
Physician/Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Dentist/Address: \_\_\_\_\_ Phone: \_\_\_\_\_
5. **IN CASE OF INJURY OR ILLNESS, and you cannot be reached, whom do you request to take your child home or to the physician listed above?**
  - a. Name/Address: \_\_\_\_\_ Phone: \_\_\_\_\_
  - b. Name/Address: \_\_\_\_\_ Phone: \_\_\_\_\_
6. Conditions requiring emergency care:
  - a. Allergic sting \_\_\_\_\_
  - b. Diabetic \_\_\_\_\_
  - c. Epileptic \_\_\_\_\_
  - d. Other \_\_\_\_\_
7. Known Allergies \_\_\_\_\_
8. On Medication \_\_\_\_\_

Please provide exact information for care in the event of emergencies noted on items 7 and 8 above.  
**None**

APPROVAL OF PROCEDURES FOR NECESSARY MEDICAL ATTENTION

**In a necessary situation where we cannot be contacted, we hereby authorize the hospital to follow the procedures listed below:** This authorization gives the power of approval for necessary medical attention as recommended by a licensed physician or surgeon, including x-ray examination, anesthetic, medical or surgical diagnosis, treatment, and hospital care. Neither the principal nor the school district will assume any financial responsibility for this action.

1. Time and situation permitting, to make reasonable attempts to contract persons identified.
2. When said persons cannot be contacted, the principal is to act on our behalf.
3. Time and situation permitting, to contact the following ambulance service, medical doctor or hospital as required.

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_  
Ambulance Service: Tracy Phone: 911

\_\_\_\_\_  
Parent's signature

**PLEASE COMPLETE OTHER SIDE OF FORM!**

My Child goes **Home** after school:  
\_\_\_ **on the Bus** \_\_\_ **Walks** \_\_\_ **Parent will pick up**

Other: (name, address, city) \_\_\_\_\_

\_\_\_\_\_ **on the Bus** \_\_\_ **Walks**

## **SNOW EMERGENCY INFORMATION**

In case of a snow emergency and the buses cannot run, please give the name, address, and telephone number of a place, in Tracy, where your child(ren) could stay. **This person should be contacted ahead of time so they will be expecting your child.**

\_\_\_\_\_ Student Goes Home

Otherwise, the student goes here: \_\_\_\_\_

Street Address: \_\_\_\_\_

Phone Number: Home \_\_\_\_\_ Cell \_\_\_\_\_

**For the safety of your child(ren), please complete the following information:**

The following people have permission to pick my child(ren) up from school:

The following people **DO NOT** have permission to pick my child(ren) up from school:

\_\_\_\_\_

\_\_\_\_\_  
Custodial Parent Signature

Please list any younger siblings and their date of birth.

Full Name	DOB
_____	_____/____/____
_____	_____/____/____
_____	_____/____/____
_____	_____/____/____

“USDA is an equal opportunity provider.”

St. Mary’s School is a Christ-centered school where all enter to learn and exit to serve.