BISHOP VEROT
CATHOLIC HIGH SCHOOL

Students Full Legal Name: _____ Date: _____
Last First Mi

Grade: _____ SS #: _____ DOB: _____

Address: _____ Home Phone: _____

_____ Student Cell #: _____

Student Lives With: Circle One Mother/Step Mother

Name: _____ E-mail _____

Work Phone: _____ Cell Phone: _____

Student Lives With: Circle One Father/Step Father

Name: _____ E-mail _____

Work Phone: _____ Cell Phone: _____

Guardian: _____ Cell Phone: _____

HEALTH INFORMATION

Parent's Statement: I accept responsibility for notifying the school of any changes in home or business address or phone numbers. In the event of illness or accident and I cannot be immediately contacted, I give my permission to have my child moved by ambulance to a hospital for immediate attention. I also assume responsibility for payment of same. In case of accident or illness, I request that the school contact me. If I am unable to be reached, I authorize the person listed below to be contacted to care for my child until I can be reached.

Date: _____ Signature of Parent/Guardian: _____

Emergency Contact Person: _____ Cell: _____

Allergies: _____

Please note any medical conditions that the school should record: _____

_____

Is student on daily medication? List medication and dosage: _____

_____

Preferred Hospital: _____

Insurance Carrier: _____ Policy #: _____

Family Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Confidentiality will be maintained with the School Health Office concerning students and their individual needs and health concerns.