WESTERN HARNETT MIDDLE SCHOOL

DATE:_____/_____/_____

STUDENTS NAME:_____ MALE FEMALE

STUDENTS BIRTHDATE:_____/_____/_____

PARENT/GUARDIAN NAME:_____RELATIONSHIP TO CHILD_____

PHYSICAL ADDRESS:_____CITY_____ZIP_____

MAILING ADDRESS:_____ CITY_____ZIP_____

HOME PHONE #_____/_____/_____ CELL #_____/_____/_____WORK#_____/_____/_____

ADDITIONAL EMERGENCY CONTACT NUMBERS IF PARENTS CAN NOT BE REACHED AT THE ABOVE NUMBERS.

NAME OF INDIVIDUAL_____ _____NUMBER_____/_____/_____

NAME OF INDIVIDUAL_____ _____NUMBER_____/_____/_____

SCHOOL ATTENDING:_____UPCOMING GRADE:_____

SHIRT SIZE Small Medium Large X Large XX Large

WILL THE STUDENT NEED TRANSPORTATION FROM HOME TO SCHOOL? YES NO

WILL THE STUDENT NEED TRANSPORTATION FROM SCHOOL TO HOME? YES NO

IF YOU ANSWER YES TO THE QUESTION ABOUT TRANSPORTATION PLEASE GIVE US A DETAILED DESCRIPTION OF WHERE YOUR HOME IS LOCATED:_____

_____

_____

_____

_____

WHO MAY WE RELEASE YOUR CHILD TO? WE WILL ONLY RELEASE STUDENTS TO INDIVDUALS LISTED BELOW.

NAME:_____RELATIONSHIP TO CHILD_____

NAME:_____RELATIONSHIP TO CHILD_____

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MEDICAL STATEMENT

STUDENTS NAME:_____DOB_____/_____/_____AGE_____

PHYSICAL ADDRESS:_____CITY_____ZIP_____

MOTHERS INFORMATION		FATHERS INFORMATION	
NAME		NAME	
PHONE#		PHONE#	
CELL #		CELL#	
WORK #		WORK#	
E-MAIL		E-MAIL	
OTHER EMERGENCY NUMBERS			
Name		Name	
Contact #		Contact #	
Relationship		Relationship	

MEDICAL HISTORY	YES	NO	MEDICAL HISTORY	YES	NO
1. Asthma			6. Currently using drugs or medications		
2. Allergy to drugs, food or medication			7. Prolong Illnesses of one week or more		
3. Birth Deformities			8. Contact lenses or glasses		
4. Pre-existing injury currently under treatment			9. Medical conditions currently under treatment		
5. Is the child a diabetic			10. Other		

List all drugs and Medication currently being used and explain other comments to yes here:

_____

_____

_____Please note that no staff member will administer medication to the student without a medical physicians documentation. If your child has life threatening medical issues, a plan of action will need to be completed.

INSURANCE INFORMATION:

INSURANCE PROVIDER:_____POLICY HOLDERS NAME:_____

POLICY NUMBER_____GROUP NUMBER:_____

NAME OF CHILD'S PHYSICAN:_____PHONE NUMBER:_____/_____/_____

NAME OF CHILD'S DENTIST:_____PHONE NUMBER:_____/_____/_____

NAME OF PREFERRED HOSPITAL:_____PHONE NUMBER:_____/_____/_____

PARENTAL CONSENT:

The law requires that parental permission be obtained for operative procedures on minors. The parent/guardian should sign the following consent form so that such procedures may be carried out in the event of an emergency without delays to operative procedures. No operation will be performed, except in emergency, without parents being contacted and fully informed.

I_____Parental/Guardian of_____give permission for such diagnostic, therapeutic, and operative procedures as may be deemed necessary for my son/daughter. I hereby state that Solid Foundations, Inc. Kids Rock program is not responsible for any pre-existing injury or recurrence of undisclosed injury or illness or the administration of any medications of the above individual.

Date:_____ Signature_____