I give my permission for Emergency Medical:

Transportation _____Yes _____No

Treatment _____Yes _____No

_____ _____

Parent/Guardian Signature Date

Immunization Information

Please provide a copy of your child's immunization record along with this form. The information should include names and dates of vaccinations and the name of the medical facility or the Doctor's name.

For office use only:

_____Medical exemption (attach copy) Date_____

_____Religious exemption (attach copy) Date_____

Date enrolled_____

Date disenrolled_____

Admission Record
Children of Faith School

Child's Name _____ Birth Date _____ Sex _____

Street Address _____ Home Phone _____

Father's Name _____ Mother's Name _____

Business Name and Address _____ Business Name and Address _____

Business Phone/Cell Phone _____ Business Phone/Cell Phone _____

If your child has any allergies or other medical conditions, please list:_____

_____

Emergency Contacts

Names and phone numbers of two family friends or relatives in the local area who can be contacted in case of an emergency:

Name of first emergency contact _____ Phone _____

Name of second emergency contact _____ Phone _____

Name of Child's Physician _____ Phone _____

Name of Emergency Medical Center _____ Phone _____

(Over)