WINGS MINISTRY OF EDUCATION REGISTRATION FORM

Student Name Email Address_____

_____

Legal Last First Middle

Date of Birth _____ Gender: M/F Race: _____

Contact Phone# _____

Street Address _____

City and Zip Code _____

Mailing address (if different from above)

_____

Parent or Guardian with whom living _____

Emergency Contact (other than parent/guardian)

_____

Name Phone Number

At least one Parent/Guardian place of employment (including phone number)

_____

School now attending _____ Phone Number _____

Is student court involved: Nature of involvement and additional information needed

If Student has current IEP or 504 Plan: Additional information needed

Additional Comments: _____

_____

_____

_____

_____

WINGS MINISTRY OF EDUCATION

EMERGENCY MEDICAL FORM

Name _____

Address _____

Telephone _____ Date of Birth _____

Purpose – This allows parents/guardians to authorize the provision of emergency medical treatment and care for children who become ill or injured while under program authority.

Contact person: _____

Relationship _____ Phone Number _____

Please indicate if your child has any of the following:

1. Allergies (please list) _____
2. Medications (please list) _____
3. Inhalers (please list) _____
4. Are there any other medical concerns or conditions concerning the child's medical history to which medical personal should be alerted?

Administration of Prescription Medication

Does child require medication during Program hours or events and functions?
(This includes asthma inhalers) Yes No

CONSENT/REFUSAL FOR TREATMENT INFORMATION

Part I : I grant Consent for Treatment

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment of deemed necessary by the appropriate medical professional, or in the event a designed practitioner is not available, by another licensed physician or dentist; the transfer of the child to any hospital reasonably accessible.

Parent Name (print) _____
Signature of Parent/Guardian _____
Date _____

Part II: I Refuse to Grant Consent for Treatment

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 program's authority to take the following actions:

_____
_____
_____

Parent Name (print) _____
Signature of Parent/Guardian _____
Date _____