IMMACULATE CONCEPTION ACADEMY

REGISTRATION INFORMATION FOR THE HEALTH ROOM

Name of Child:____Date of Birth:_____________

For School Year:______________________ Grade in School:______________________

Home Address:____ Phone:_________

Father's Name:____

Father's Business Address: ____ Phone:___________

Mother's Name (include Maiden): ________________________________ Phone:__________________

Mother's Business Address:____ Phone:____________

Alternate Person to be Notified: ____

Address:____ Phone:_____________

Doctor to be Notified: ____ Phone:_____________

Alternate Doctor: ____ Phone:_____________

Hospital Preferred:____ Phone:______________

Is your child allergic to any drugs? ____________ If "Yes" please itemize on reverse side.

If emergency treatment is required before parents can be reached, may the school authorities send this child to the Doctor or Hospital most accessible? _______Yes ______No

Date:__________________ Signature of Parent/Guardian:____

THE HEALTH RECORD OF THE CHILD'S IMMUNIZATION IS REQUIRED, PLUS THE DATES FOR THE DOSES.

D.P.T. (4 doses) ______ _______ ______ ______

Polio (4 doses) ______ ______ ______ ______

MMR ______ ______

Hep. B ______ ______ ______

Varivax ______