

**STUDENT INFORMATION:**

Student's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

School: \_\_\_\_\_ Fall Grade: \_\_\_\_\_ Gender: \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION:**

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Father's Home Phone: \_\_\_\_\_ Mother's Home Phone (If Different): \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_ Mother's Work Phone: \_\_\_\_\_

Father's Cell Phone: \_\_\_\_\_ Mother's Cell Phone (If Different): \_\_\_\_\_

Family's Most Often Checked Email Address: \_\_\_\_\_

**EMERGENCY CONTACT (LOCAL):**

Name: \_\_\_\_\_ Relationship To Student: \_\_\_\_\_

Contact Number(S): \_\_\_\_\_

**INSURANCE INFORMATION:**

Medical Insurance Provider: \_\_\_\_\_ Provider's Phone Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's Phone Number: \_\_\_\_\_

**MEDICAL INFORMATION:**

Known diseases or conditions (circle) asthma, heart condition, kidney, epilepsy, other: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Date of last Tetanus shot (month/year): \_\_\_\_\_

I give permission for Christ Community Church to photograph my child for promotional use within the ministry setting.

I give permission for Christ Community Church to administer basic first aid care to my student.

\_\_\_\_\_  
Parent/Guardian Signature (required)

\_\_\_\_\_  
Date

\*\*\*all information is confidential\*\*\*

**For office use only:** Last Name Initial: \_\_\_\_\_ Date Processed: \_\_\_\_\_