St. Raphael Catholic School

Clinic Card

Dual Parent Notification INSTRUCTIONS: (PLEASE TYPE OR PRINT). This card must be completed by the parent or guardian and returned to the school.

LEGAL NAME OF STUDENT (Last, First, Middle Init.)	Social Security Number			Date of Birth	Grade
			Female:		
ADDRESS: STREET APT/LOT# CITY ZIP	HOME PHONE			Notes	
			Contacts:		
MOTHER'S NAME/LEGAL GUARDIAN(circle one)	Home Phone:	Business Phone:			
	Email:	Cell Phone:			
FATHER'S NAME/LEGAL GUARDIAN(circle one)	Home Phone:	Business Phone:			
	Email:	Cell Phone:			
STEP PARENT'S NAME (if applicable)	Home Phone:	Business Phone:			
	Email:	Cell Phone:		Names & Grades of Siblings at This School: 1.	
NAME OF PERSON *WHO WILL ASSUME RESPONSIBILITY IF P ARENT CANNOT BE REACHED PHONE:			#1 NAME:	2	
NAME OF PERSON*WHO WILL ASSUME RESPONSIBILITY IF PARENT CANNOT BE REACHED PHONE:.			#2 NAME:	3	
				4	
PHYSICIAN'S NAME PHONE	HOSPITAL PREFERENCE	DATE OF LAST TETANUS SHOT		MEDICATIONS: Yes No Please List	
DENTIST'S NAME PHONE	ALLERGIES - Please List any your child may have			Other Health Problems:	

Is there any court order restricting access to the student and/or student records? **Yes or No**

If yes, **please provide** the school with a certified copy.

In case of accident or serious illness, the school will contact the **parent/guardian.** If the school is unable to contact the **parent/guardian** or person(*) **designated above,** the school will contact the physician or will make necessary arrangements for **immediate** treatment. Payment of fees will be **assumed** by the **parent/guardian.**

I have reviewed and understand the conditions of the clinic emergency information card.

Parent Signature: _____ Date: _____

Dismissal Instructions

PLEASE CHECK ONE

- ☐ I understand that my child will be dismissed according to the normal plan arranged by the school. If my child in grade K thru 8 is not picked up within 20 minutes of the announced dismissal time, I request that they be placed in the St. Raphael Catholic School Extended Day Program and agree to pay the appropriate fees.
- ☐ I request that the following instructions be followed if agreed by the school _____

Authorized persons to release my child to at scheduled dismissal time

I request that the school release my child to only the persons listed below. I have informed these people that they may be required to produce proper identification if they are not personally known to representatives of the school. We will not release any students to anyone before dismissal time unless specifically authorized by you.

Name of authorized person _____ Relationship _____ Phone

Name of authorized person _____ Relationship _____ Phone

Name of authorized person _____ Relationship _____ Phone

Name of authorized person _____ Relationship _____ Phone

I fully understand the purpose of this card and the information contained herein. In case of emergency, I request that the school contact I/we the parent(s) listed on the reverse side. If not available, I authorize the school to make whatever emergency decisions necessary for the immediate health and safety of my child.

Parent(s) or
Guardian's Signature _____ Date _____