CALICO ROCK HIGH SCHOOL
REGISTRATION / EMERGENCY
TREATMENT CALL FORM
School Year_____

Student's Name_____Grade_____

Address_____ City_____ Zip_____
P.O. Box or Route
SS #_____ Birth Date_____ Phone_____

City & State of Birth_____ Miles to School_____

Physical Address_____
THIS MAY BE A 911 ADDRESS OR AN ADDRESSESS THAT UPS WOULD USE. THIS IS NOT A P.O. BOX OR ROUTE

Has this student ever been expelled from another school district? If yes, please explain. Please give specific dates and reason.

EMERGENCY CALLS:

Mother_____ Home #_____Work #_____

Father_____ Home #_____Work #_____

If mother or father can't be contacted, whom else may we call in case of an emergency?
_____ Phone #_____

_____ Phone #_____

_____ Phone #_____

IMPORTANT: List any health conditions, severe allergies or daily medications:

Explanation_____

Physician_____ Phone #_____

I, the undersigned, do authorize officials of Calico Rock Public School to contact directly the physician names on this form and to authorize the named physician to give treatment as deemed necessary in an emergency. The school officials are authorized to take necessary action in the event parents and persons named on this form cannot be contacted. I will not hold the School District financially responsible for the emergency care and/or transportation for this child.

_____ _____
Signature of Parent or Guardian Date