REGISTRATION/EMERGENCY MEDICAL AUTHORIZATION FORM
XENIA COMMUNITY SCHOOL DISTRICT

Date: _____

Student Name: _____ School:

_____

Birth date: _____ Age: _____ Sex: M F Grade: _____

Teacher:_____

Address: _____City, State, Zip: _____Home Phone:

(____)_____

Bus Student: YES NO Bus # _____ Your child's directory information released? YES NO E-Mail:

_____

Father's Names: _____Employer: _____ Work/Cell:

_____

Mother's Names:_____Employer: _____ Work/Cell:

_____

Guardian:_____ Employer: _____

Work/Cell:_____

If parents are separated or divorced, with whom does the student live?:

_____

Name of person(s) **NOT** authorized to take child from the school:

_____

(Court documentation is needed to enforce)

List name of local person(s) other than parents authorized to take child from the school:

Name: _____Relationship: _____ Phone:

_____

Name: _____Relationship: _____ Phone:

_____

List allergies and/or medical problems:

_____

List medications:

_____

List names of other children attending Xenia Community Schools: Name/School:

_____

_____

_____

NOTE: IT IS THE PARENT'S RESPONSIBILITY TO NOTIFY THE SCHOOL IMMEDIATELY OF CHANGES TO ANY OF THE ABOVE INFORMATION.

CLINIC FILE CARD

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