

**PREK 3 YEAR OLDS THROUGH 3<sup>rd</sup> GRADERS**

**St. Louis School After-School Care Program 2009-10**

Student's Name: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Father, Mother/Legal Guardian

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: Texas Zip: \_\_\_\_\_

Birthdate of Child: \_\_\_\_\_

Telephone where parents or guardian may be reached:

\_\_\_\_\_  
Print Name of Father or Guardian (work) \_\_\_\_\_ (home/cell) \_\_\_\_\_

\_\_\_\_\_  
Print Name of Mother or Guardian (work) \_\_\_\_\_ (home/cell) \_\_\_\_\_

\_\_\_\_\_  
Other (Friend or relative) (work) \_\_\_\_\_ (home/cell) \_\_\_\_\_

People who have permission to pick up child:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Estimated time of pick up: \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT**

**ALLERGIES OR OTHER MEDICAL INFORMATION:**

(We), the parents of

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Child's Name)

a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered by a physician on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but it is given to provide authority and power on the part of the "Bearer" to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his judgment may deem advisable.

\_\_\_\_\_  
Parent's Signature/Legal Guardian