

Joseph Academy

1101 GREGORY STREET DES PLAINES IL 60016 847.803.1930

District: _____ Room: _____ Start Date: _____

Parent Documentation Sheet

Student Name: _____ Birth Date: _____

Address: _____ City: _____ Zip Code: _____

Legal Guardian(s): _____ Relationship: _____

Father

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Business Phone: _____

Mother

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Business Phone: _____

Emergency Contact Person(s)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Relevant Health Information

Family Doctor: _____ Phone: _____

Insurance Co.: _____ Allergies: _____

Medication/Dosage: _____

I authorize Joseph Academy to call our family doctor and to take my child to the nearest hospital emergency room and for them to treat my child in the event of any emergency.

STUDENT S.S. # **Signature (Parent/Guardian)** **Date**