

John Paul II High School Health Registration Information

(Attach immunizations if this is your first year at JP II) Grade: _____

Last Name: _____ First Name: _____ Middle Name: _____ Gender: _____

Address & Apt Num: _____ City: _____ Zip: _____ Date of Birth: _____

Phone: _____ Cell phone: _____ Home email: _____ Student lives with: _____

<p>Name: _____ Relation: (Circle one) Parent Guardian Step Parent: DOB: _____</p> <p>Residence: _____</p> <p>Employer: _____</p> <p>Work No: _____ Cell No: _____</p> <p>Email: _____</p>	<p>Name: _____ Relation: (Circle One) Parent Guardian Step Parent DOB: _____</p> <p>Residence: _____</p> <p>Employer: _____</p> <p>Work No: _____ Cell No: _____</p> <p>Email: _____</p>
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Local Contact Information (other than parents) List in order of preference. Those designated below are authorized to pick up my student from school in an emergency:

Contact 1: _____ Daytime Phone: _____ Relationship: _____

Contact 2: _____ Daytime Phone: _____ Relationship: _____

Contact 3: _____ Daytime Phone: _____ Relationship: _____

Please notify school nurse of any health problems the above named child might have including behavioral and learning difficulties:

Health Problem #1: _____ Doctor: _____ Phone: () _____

Current Treatment: _____ Instructions for school: _____

Health Problem #2: _____ Doctor: _____ Phone: () _____

Current Treatment: _____ Instructions for school: _____

Health Problem # 3: _____ Doctor: _____ Phone: () _____

Current Treatment: _____ Instructions for school: _____

A written statement from the student's parent/guardian or physician must support all histories of varicella illness (chicken pox). _____ has had varicella (chicken pox) disease on or about (date). _____

I, the undersigned, do hereby authorize employees of JOHN PAUL II HIGH SCHOOL to contact directly the persons and health care providers named on this form, and do authorize the named physicians, clinics and/or hospitals to render such treatment as may be deemed necessary for the transportation and health care of said child. In the event the physicians, other persons named on this form, or parents cannot be contacted, the school employees are hereby authorized to take whatever action is deemed necessary, in their judgment, for the health of the aforesaid child. (Section 35.01, Texas Family Code). I will not hold the school financially responsible for the emergency care and/or transportation for said child.

I request that the physicians and staff of the medical facility perform any diagnostic procedures, treatment procedures, operative procedures, and x-ray treatments and anesthetics as may be necessary in the diagnosis and treatment of my child. I authorize the medical facility to dispose of any specimen or tissue taken from named person.

I certify I am a parent with legal control of the child, the child's legal guardian, or have other court ordered control of the child. I understand that I must notify JOHN PAUL II HIGH SCHOOL in writing to change any information on this form or to revoke any consent given herein. I understand it is a penal code offense to falsify information for enrollment. I testify all information on this document to be true and correct.

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____

Printed Name of Student _____ Signature of Student (if 18 or more years of age) _____