VANGUARD REGISTRATION FORM

H.S.E._____

455 Rhodes Road, Bandera, Tx 78003

Parent E-Mail Address: _____

STUDENT NAME_____

DATE _____

ADDRESS_____CITY/ZIP_____

SS#_____

GRADE LEVEL_____

DOB_____ _____

PLACE OF BIRTH_____

PREVIOUS SCHOOL ATTENDED_____PHONE_____

ADDRESS_____CITY/ZIP_____

FATHER'S NAME_____**CELL#**_____

ADDRESS_____CITY/ZIP_____

EMPLOYER_____WK#_____

HOME#_____OTHER#_____

MOTHER'S NAME_____**CELL#**_____

ADDRESS_____CITY/ZIP_____

EMPLOYER_____WK#_____

HOME#_____OTHER#_____

GUARDIAN'S NAME_____**CELL#**_____

ADDRESS_____CITY/ZIP_____

EMPLOYER_____WK#_____

HOME#_____OTHER#_____

ALTERNATE ADULTS TO CONTACT IN EMERGENCY

NAME _____RELATIONSHIP TO STUDENT_____

HOME#_____CELL#_____WK#_____

NAME _____RELATIONSHIP TO STUDENT_____

HOME#_____CELL#_____WK#_____

CHURCH AFFILIATION_____

MEDICAL INFORMATION

SERIOUS ALLERGIES_____

TREATMENT/MEDICATION_____

PHYSICIAN_____PHONE#_____

MY CHILD **MAY** RIDE WITH (LIST RELATIONSHIP) _____

_____

MY CHILD **MAY NOT** RIDE WITH_____

_____

PARENT/GUARDIAN SIGNATURE_____

DATE_____

VANGUARD AUTHORIZATION FOR MEDICAL CARE

455 Rhodes Road, Bandera, Tx 78003

Student Name _____Birth Date _____

Physician _____Phone # (_____)_____

Address _____City/Zip_____

Having legal custody of the above-named student, I do hereby authorize Vanguard to consent to any x-rays, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the above-named student under general or special supervision and upon the advice of a licensed physician, surgeon, or dentist. In giving this consent, I recognize and understand that in any situation where the above named student required immediate medical or hospital care, it may not be possible to contact me and in such situations I will not necessarily be able to knowledgeably evaluate and choose among available alternative treatments or procedures, if any, or to evaluate the risks attendant upon each, and the risks incident to and choose the necessary treatment from any available alternatives or to render such care and perform such care and perform such treatment as he/she in their professional judgment determines to be necessary for the health or safety of the above named student. Furthermore, I understand that the above-named student may receive cough drops, antacids, acetaminophen, ibuprofen, topical anti-itch or topical antibiotic preparations for wounds for the relief of minor medical situations. For needs beyond this treatment, the staff will contact parent/guardian.

Known allergies (insects, plants, foods, Rx) _____

_____

_____

Parent/Guardian _____ Date _____

Address _____City/Zip_____

Cell # (_____)_____

Home # (___)_____Work (____)_____

Vanguard Medical Alert Form

Dear Parent's,

This letter is going out to all families that have children with severe allergies.

As you are aware, we do not have a nurse on staff at Vanguard. We will do everything in our power to keep your child safe while at school, by making every effort to follow the directions that you have left with us. We will have your child's medication kept with their homeroom teacher. These teachers will also have one parent's cell phone number programmed into their phone so that you can be called immediately in case of an emergency.

Once again, we will make every effort to keep your child safe at school. However, in good faith, we cannot promise more than we can offer. Please be aware that we have your child's best interest at heart, and we have a history of upstanding performance in these types of situations.

We ask for your signature at the bottom of this page, acknowledging the above information. Please sign and date this for your child's records.

Thank you for supporting us while we support you!!!!

_____ _____

Signature date