NOTRE DAME REGIONAL HIGH SCHOOL
265 NOTRE DAME DRIVE * CAPE GIRARDEAU, MO 63701

Please verify all information and make corrections with a red pen.

Fee ___________

Check # ___________

Date ___________

School Year: ___________

Entering Grade: 9 10 11 12

Changes Made: ______ **No Changes:** ______

______________________________ **Signature of Parent / Guardian**

______________________________ **Printed Name of Parent / Guardian**

Please indicate which parent would need to be listed as the Primary Contact (circle): Mother Father Other_____________

FULL LEGAL NAME	: First Middle Last Suffix	PAR./GUAR.	:
NICKNAME	:	HOME PH.	:
STUDENT STREET	:	GRADE	:
STUDENT CITY	:	PARISH	:
STUDENT STATE	:	ELEM. SCHOOL	:
STUDENT ZIP	:	CATHOLIC/NON	:
GENDER	:	STUDENT SS#	:
BIRTH DATE	:	RACE	:
STUDENT CELL#	:	COUNTY	:
		SCHOOL DIST	:

Custodial Parents / Guardians Information

In cases of divorce, the legal custodial parent is (circle one): Mother Father Joint

Fathers Name	:	Mothers Name	:
F-Cell Phone	:	M-Cell Phone	:
F-Work Phone	:	M-Work Phone	:
Fathers Email	:	Mothers Email	:
FATHER SS#	:	MOTHER SS#	:
FATHER DOB	:	MOTHER DOB	:
OCCUP-F	:	OCCUP-M	:
F-Employer	:	M-Employer	:

Non Custodial Parent Information

ONLY IF PARENTS ARE DIVORCED, please complete the following:

Should Joint/Non-Custodial Parent (ex-spouse with whom child does not live) be contacted in case of emergency and receive all school mailings? Yes No

NC Parent	:	NC Occupation	:
NC Address	:	NC Employer	:
NC City	:	NC Work Phone	:
NC State	:	NC Bingo Team	:
NC Zip Code	:	NC SS#	:
NC Home Phone	:	NC Email	:
NC Cell Phone	:	NC Relationship	:

Student Vehicle Information

	Primary Vehicle		Secondary Vehicle
Year	:	Year	:
Make	:	Make	:
Model	:	Model	:
Color	:	Color	:
Plate	:	Plate	:

Medical/Emergency Consent Form

AUTHORIZATION for school officials in case of emergency: As Parent(s)/Guardian(s) of the above student, I/we give consent for the school to contact a physician or hospital of its choice for such medical care as is reasonably necessary for the welfare of the student. I/we understand that the school personnel will first make efforts to contact the parent(s) or emergency contacts listed below. If the student's condition warrants immediate medical attention and the parent(s) or individuals below cannot be reached in a timely manner, I/we understand that when possible the school personnel will contact the doctor and the hospital listed below. I/we understand that in the event medical attention is deemed necessary and phone contact cannot be made in a timely manner, Notre Dame personnnel may seek appropriate services and proceed with recommended medical attention.

YES______ NO______ Date:________

Signature of Parent / Guardian ______________________ **Printed Name of Parent / Guardian** ______________________

In case of emergency at the school or at a school activity , if the parents/ guardians are unavailable contact the following:

NAME ______________________ Relationship ______________________

Day Phone ______________________ Cell Phone ______________________ Other Phone ______________________

NAME ______________________ Relationship ______________________

Day Phone ______________________ Cell Phone ______________________ Other Phone ______________________

NAME ______________________ Relationship ______________________

Day Phone ______________________ Cell Phone ______________________ Other Phone ______________________

NAME ______________________ Relationship ______________________

Day Phone ______________________ Cell Phone ______________________ Other Phone ______________________

Please list all medical conditions, previous injuries, and allergies. (ex. ADD, Allergies, Diabetes, Contacts, Disabilities, etc.)

Please list all prescription medications.

DOCTOR'S NAME	:	Insurance Company	:
PHONE	:	Phone	:
ADDRESS	:	Policy Number	:
PREFERRED HOSPITAL	:	Primary Policyholder	: