
LAST NAME FIRST NAME MIDDLE INITIAL

HOME STREET ADDRESS CITY STATE ZIP CODE

HOME TELEPHONE (____)_____ DATE OF BIRTH: ____/____/____ AGE: ____ GENDER: M F

FATHER'S NAME FATHER'S EMPLOYER FATHER'S E-MAIL ADDRESS

FATHER'S HOME PHONE FATHER'S DAY PHONE FATHER'S CELL PHONE

MOTHER'S NAME MOTHER'S EMPLOYER MOTHER'S E-MAIL ADDRESS

MOTHER'S HOME PHONE MOTHER'S DAY PHONE MOTHER'S CELL PHONE

ADDITIONAL MAILING ADDRESS (IF A SECOND PARENT/GUARDIAN REQUIRES SCHOOL MAILINGS):

PARENT/GUARDIAN NAME RELATIONSHIP

STREET ADDRESS CITY STATE ZIP CODE

EMERGENCY CONTACTS - In the event that a parents cannot be reached, the individuals below have the authorization to pick up my child and can be reached during school hours at the number(s) listed below (please list in order of preference to be called):

1) NAME RELATIONSHIP (____)_____
DAYTIME TELEPHONE

2) NAME RELATIONSHIP (____)_____
DAYTIME TELEPHONE

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR:

I/We, the undersigned parent(s)/guardian(s) of _____, a minor, do hereby authorize La Salle Catholic College Preparatory [Administrative/Staff member as agent(s)] for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgement may deem advisable.

Insurance Co: _____ Employer: _____

Group #: _____ Policy #: _____

Primary Physician/ Provider: _____ Physician Phone: (____)_____

Hospital of choice in case of emergency: _____

List: Chronic illness or allergies: _____

Current Medications: _____

Last DPT Immunization: _____

PARENT/GUARDIAN NAME (PLEASE PRINT)

PARENT/GUARDIAN SIGNATURE

DATE

This Continuing Parental Field Trip Permission Form, when signed and returned to La Salle Catholic College Prep, will be kept on file in the Attendance Office.

The events covered by this form are for school sponsored events such as retreats, service learning, AHS Mathematics Exam, Regional Skills Competition, league band, choir and art competitions, and class field trips.

It does not apply to any traveling out of the state of Oregon or any school wide activities not listed above. Nor does it replace the Medical and Physical Examination Summary Form required for all incoming 9th grade students, and for 11th grade students to continue to participate in sports.

I agree to abide by the rules set up by the teacher/chaperone of the event I will attend. I understand that if I choose to disregard any rules or expectations, I will be asked to leave and transportation from the event will have to be arranged with my parent/guardian.

STUDENT NAME (PLEASE PRINT)

STUDENT SIGNATURE

DATE

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I give permission for my child/student to attend the event(s) listed above. She/He has permission to ride in the school bus, rented vehicle or adult driven car. I understand that if my student chooses to disregard the rules of the event, s/he will be asked to leave and I agree to be responsible to arrange transportation from the event for him/her.

I hereby authorize La Salle Catholic College Preparatory, its employees or chaperones, to secure the necessary services for my child in the event of illness, accident or injury. Further, I agree to be responsible for payment of those services.

PARENT/GUARDIAN NAME (PLEASE PRINT)

PARENT/GUARDIAN SIGNATURE

DATE

(_____) _____
DAYTIME TELEPHONE

**** Please notify the school immediately if your daytime phone number changes.**

PLEASE FILL OUT BOTH SIDES OF THIS FORM.