

FBCS Extension Programs
Information Sheet
2006-2007

Name _____ Nickname _____

Grade _____ Birthday _____ SSN _____

Address _____

City _____ State _____ Zip _____

Allergies _____

Medications _____

Parent(s) _____

Mother

Father

Phone Numbers:

Home _____

Work _____

Cell _____

Email _____

Emergency Contacts:

Name

Phone

Relationship

1. _____

2. _____

Authorized Pick-up:

Name

Phone

Relationship

1. _____

2. _____

In case of accident or serious illness, I request the school extension program to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his or her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Medical Insurance Company_____

Policy Number_____

(Please copy and attach the front and back of ID card)

Signature of Parent or Guardian_____

Name of Local Physician_____

Address_____

City_____ Zip_____

Telephone Number_____