



Divine Mercy Catholic School

1940 N Courtenay Parkway
Merritt Island, FL 32953
321-452-0263

Student Form for 2010 / 2011 Academic Year

We will make every attempt to contact you first and foremost, or the contacts noted below in the event your child has an accident or serious illness at Divine Mercy School. However, if the School fails to reach you or a designated contact, the Physician indicated on this form will be called for instruction. **Therefore, it is very important that the information which the School has on your child is always current and accurate.** If your child needs emergency care, and/or transport by ambulance, this "Release" authorizes Divine Mercy to arrange for such care or transport.

Please sign in the presence of a Notary Public and return with your registration papers. (A notary is available in the school office.) **You must sign a release form for each child you are registering.**

Student Name: _____
Date of Birth: _____
Grade 10/11: _____
Youngest in Family (at Divine Mercy): _____

Nationality/Race: _____
Gender: _____
Social Security Number: _____

Primary Contact Information:

In case of emergency, who should be contacted first? Mother _____, Father _____, or Other _____

Father / Male Guardian

Name: _____
Relationship: _____
Home Phone: _____
Work No.: _____
Cell No.: _____

Mother / Female Guardian

Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____
Cell No.: _____

Is there someone to whom your child may not be released? _____

Contacts (other than parents) to whom your children may be released:

- | | | |
|----------------|---------------------|------------------|
| 1) Name: _____ | Relationship: _____ | Daytime #: _____ |
| 2) Name: _____ | Relationship: _____ | Daytime #: _____ |
| 3) Name: _____ | Relationship: _____ | Daytime #: _____ |
| 4) Name: _____ | Relationship: _____ | Daytime #: _____ |
| 5) Name: _____ | Relationship: _____ | Daytime #: _____ |

Medical Conditions (if applicable):

Asthma Hypoglycemia Hyperactive
 Diabetic Visual Epileptic

Other: _____

Allergies (if applicable):

Bee/Wasp/Red Ant Bite _____
Food/Types: _____
Medicines: _____
Other: _____

Physician's Name: _____

Insurance Co Name: _____

Daytime Phone #: _____

Group #: _____

Sacraments Received:

Baptism: _____
Penance: _____
Eucharist: _____
Confirmation: _____

Permission is granted for the school to conduct the following screenings:

Vision: _____
Hearing: _____
Scoliosis (applicable to 7th & 8th grade): _____

*State of Florida
County of Brevard*

_____, parent / guardian of the child named above, who is personally known to me or who has shown the following identification _____ has been duly sworn and subscribed before me this _____ day of _____ (month), _____ 2010 (year) and agrees to the above "Release Form" and will abide by its contents.

Signature of Parent / Guardian: _____

Signature of Notary Public: _____

NOTARY STAMP: