



**DIVINE MERCY**  
**Catholic Academy**  
 Developing Skills for the 21st Century

**Divine Mercy Catholic Academy**

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

**Student Form for 2011 / 2012 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 Academy. 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 11/12: \_\_\_\_\_  
 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 7<sup>th</sup> & 8<sup>th</sup> 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), \_\_\_\_\_ (year) and agrees to the above "Release Form" and will abide by its contents.

**Signature of Parent / Guardian:** \_\_\_\_\_

**Signature of Notary Public:** \_\_\_\_\_

**NOTARY STAMP:**