



AVIAT REGISTRATION FORM

STUDENT INFORMATION		
Student(s) Last name:	First:	Grade/ Teacher:
PARENT AND GUARDIAN INFORMATION		
Fathers Name:	Fathers Cell Phone:	
Mothers Name	Mothers Cell Phone:	
Street address:	City, State, Zip	Home phone no.: ()
Fathers Employment:	Work phone no:	Email Address:
Mothers Employment:	Work phone no:	Email Address:
If both parents do not have custody, please indicate custody below. Copies of Court documents regarding custody must be provided.		
Person with Legal Custody:	Address:	
Employment:	Work phone no:	Email Address:
STUDENT HEALTH INFORMATION		
Please list any chronic physical problem, developmental information or special accommodations needed.		
Please list any allergies to food or medication. Please include action to be taken in an emergency caused by this allergy.		
Pediatrician:	Address:	Phone no:
EMERGENCY CONTACT INFORMATION		
Please provide 2 emergency contacts (NOT PARENTS)		
Name:	Relationship:	Phone no:
Address:		
Name:	Relationship:	Phone no:
Address:		

PERSONS AUTHORIZED TO PICK UP CHILD

Name:

Relationship:

PERSONS NOT AUTHORIZED TO PICK UP CHILD

If a parent, copies of court documents must be provided.

Name:

Relationship:

The Aviat Care program agrees to notify the parent/guardian whenever the child becomes ill and the parent/guardian will arrange to have the child picked up as soon as possible if requested by the director.

The parent/guardian authorizes the Aviat Care program to obtain immediate medical care if any emergency occurs when the parent/guardian cannot be located immediately.

Parents will inform the Aviat Care program within 24 hours if the child or any member of the household has developed any reportable communicable or life-threatening disease.

Parents agree to pay their Aviat Care bill within one week of receipt.

PLEASE INCLUDE \$45 REGISTRATION FEE WITH REGISTRATION FORM.

Patient/Guardian signature

Date