## 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 CHILDIf 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 |  |