# Vital Information Card 2016-2017

Please fill out form completely

Child's Name: ____________________________ Teacher: ___________________ Grade: _________

Date of Birth: ___________ Address: ____________________________________________________

City: _____________________ State: __________ Zip: __________________

____ (check here) My child will be the youngest or only student at MPCS during the 2016/2017 school year.

Parent Name: _____________________

Email: ___________________________

Home#: __________________________

Cell#: ___________________________

Work#: __________________________

Address: _________________________

City: _____________ Zip: ___________

Employer: ________________________

Address: __________________________

City: _____________ Zip: ___________

Parent Name: ____________________________

Email: _________________________________

Home#: ________________________________

Cell#: __________________________________

Work#__________________________________

Address: ________________________________

City: ________________ Zip: ______________

Employer: _______________________________

Address: __________________________________

City: _________________ Zip: ______________

## Pick-Up List

Name: ___________________________

Phone#: __________________________

Address: __________________________

City: ___________ State: ___ Zip: _____

Name: _______________________________

Phone#: ______________________________

Address: ______________________________

City: ____________ State: ____ Zip: _______

## Emergency Contacts

(Other than parent/guardian)

Name: _________________________

Phone#: ________________________

Address: ___________ City: ______ Zip: ____

Relationship to child: __________________

Name: ___________________________

Phone#: ___________________________

Address: _________ City: _________ Zip: _____

Relationship to child: ____________________

**Not Permitted to Pick-Up**

Name: ___________________________ Name: ___________________________

Court Oder? ____ yes ____ no Court Order? ______ yes ______ no

**If you answer yes to any of the following, please contact the Clinic Aide prior to August 17.**

Appropriate forms will be given to you that will need to be signed by parent(S), physician and the Clinic Aide. Without a complete Health Care Plan, your child will not be able to start on the first day of school.

Does your child have any food allergies? _____yes _____no

Please List: ______________________________________________________________

Does your child have any other allergies? _____yes ______no

Please List: ______________________________________________________________

Does your child have any form of asthma? ____yes ______no

Does your child need an inhaler? ____yes ______no

Does your child take any medication, prescription or over-the-counter, on a regular basis? ___yes ___no

Please Explain:

Does your child have any other health conditions that may require special attention? ___yes ___no

Please Explain:

Pediatrician: ______________________________________________________________

Address: ______________________ City: ______________________________ Zip: __________

Phone: ____________________________________ Fax: __________________________________

Dentist: __________________________________________________________________

Address: ______________________ City: ______________________________ Zip: ___________

Phone: ____________________________________ Fax: ___________________________________

Preferred Hospital **(in case of Emergency)**: ___________________________________________

Address: _______________________ City: _____________________________ Zip: ____________

Phone: _____________________________________ Fax: __________________________________

**Parent Print:** ___________________________ **Parent Print:** ___________________________

**Parent Signature:** ________________________ **Parent Signature:** ________________________

**Date:** __________ **Date:** _________