

Form E – 1
Enrollment Information and Medical Authorization
2010 – 2011 Academic Year



Check if new address or telephone number

Deadline: August 1, 2010

STUDENT

LAST NAME: _____ FIRST _____ GRADE _____

HOME ADDRESS _____

CITY _____ STATE/PROVINCE _____

ZIP/COUNTRY CODE _____ COUNTRY _____

HOME TELEPHONE _____ HOME SCHOOL DISTRICT _____

LIVES WITH: Both Parents _____ Mother Only _____ Father Only _____ Joint Custody _____

If joint custody, when does student live with each parent? _____

Siblings at AOA _____

RACE (Please check one):

African America Asian American European American (Caucasian) Latino/Hispanic American
 Middle Eastern American Multiracial American Native American Pacific Islander American
 International Other _____

MOTHER _____ GUARDIAN _____ OTHER _____

FATHER _____ GUARDIAN _____ OTHER _____

Dr. _____ Ms. _____ Mrs. _____ Other _____

Dr. _____ Mr. _____ Other _____

Last/First Name _____

Last/First Name _____

Address _____

Address _____

(if different than student)

(if different than student)

City/State/Province/Zip _____

City/State/Province/Zip _____

Telephone _____ Cell _____

Telephone _____ Cell _____

E-mail _____

E-mail _____

Business Name _____

Business Name _____

Business Address _____

Business Address _____

City/State/Zip _____

City/State/Zip _____

Job Title _____ Phone _____

Job Title _____ Phone _____

Step-Parent Name _____

Step-Parent Name _____

EMERGENCY/ROUTINE CARE MEDICAL AUTHORIZATION

Purpose: To enable parents and/or guardians to authorize the provision of **emergency, routine, and/or mental health** treatment for their student who becomes ill or injured while under the school authority when parents cannot be reached.

Physician: _____ Telephone: _____ Fax: _____

Dentist: _____ Telephone: _____ Fax: _____

I **AUTHORIZE MY CONSENT** for any required hospital admission and necessary medical/mental health treatment. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

Date _____ Signature of Parent or Guardian _____

MEDICAL INSURANCE REQUIREMENTS

****Please attach a copy of your current insurance card****

Name of Subscriber: _____ Medical Insurance Company _____

Contract Number: _____ Group Number: _____ Telephone Number: _____