STUDENT INFORMATION

MULHALL-ORLANDO SCHOOLS

20__-20__

Student's Full Name_____ Grade____ Date of Birth_____

Birth City_____ Birth State_____ Race(s)_____

Mailing Address_____City_____Zip_____

Father's Name_____ Cell Phone_____

Employer_____ Work Phone_____

Mother's Name_____ Cell Phone_____

Employer_____ Work Phone_____

Parent(s) Email_____

Name & Phone Numbers of Emergency Contact Person(s) Other Than Parents:

_____

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_____

Medical and/or Important Information (asthma, food allergies, who can/cannot pick up…)

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PARENT/GUARDIAN AUTHORIZATION TO ADMINISTER MEDICINE

_____I give Mulhall-Orlando staff permission to administer a **PRESCRIPTION/NON - PRESCRIPTION MEDICATION**, **WHICH I AM SUPPLYING, IN THE ORIGINAL BOTTLE/CONTAINER, WITH THE LABEL AND DIRECTIONS**, when needed, to my child. (Please initial)

Child's Name_____ Parent Signature_____

Date_____