STUDENT INFORMATION
Mulhall-Orlando Schools
20__-20__

Student's Full Name____ Grade _______________

Mailing Address_____________________________________ City_______________ Zip___________

Home Phone_______________________________ Student's Cell_____________________________

Father's Name_____________________________________ Employer__________________________

Work Phone_______________________________ Cell Phone_________________________________

Mother's Name____________________________________ Employer__________________________

Work Phone_______________________________ Cell Phone_________________________________

Parent Email(s)____

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

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Medical and/or Important Information (asthma, food allergies, who can or cannot pickup the student etc…)

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Parent/Guardian Authorization to Administer Medicine

_____I give Mulhall-Orlando staff permission to administer a non-prescription medication to my child. (cough drops, Tylenol, Ibuprofen, etc…)

_____I give Mulhall-Orlando staff permission to administer a prescription medication, which I am supplying, in the original bottle/container, with label directions, when needed, to my child.

Child's Name_________________ Parent Signature_________________________Date_____________