HOLY FAMILY HEALTHCARE

La Escuela Familiar Registration Form

an Outreach of Holy Family Healthcare held at St. Mary's Catholic School in Paw Paw
Saturdays, 10:45-1:30 pm for children from age 5-10 whose first language is Spanish
Please return completed form to: Holy Family Healthcare, 301 N Center, Hartford MI 49057

Name (Last Name First) ____________________

Today's Date: ______________________________ Age: ________

Child's Name: ________________________________ Date of Birth: __________

Address: ___________________________________ Phone: _______________

E-mail: ____

Current School: _________________________________ Grade: _______________

We want to help your child learn and do their best. If your child receives support and requires accommodations in the learning environment, please let us know. The Directoro/a will contact you to create a plan for supporting your child.

	Mother	Father
Name		
Mother's Maiden Name		
Marital Status		
Email Address		
Religion		

Other Children in the Family: (Please list name and age)

Your Name and Relationship to Child: ____

Child's Name: ____

Photo Release:
With my signature, I hereby grant permission to La Escuela Familiar, St. Mary's Catholic School of Paw Paw and Holy Family Healthcare to publish my child's name, photo, or video image in connection with a display, feature story or other publication as deemed appropriate by the organization or parish. I understand that this photo may be used in connection with the parish bulletin boards, parish, diocesan or youth ministry webpages, publicity materials as well other materials as deemed appropriate by the school.

Exceptions:
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Permission is granted by: ____

Printed Name: ____

Relationship to child: ____

Home Address: ____

Telephone: ____

MEDICAL TREATMENT AUTHORIZATION

To Whom It May Concern:

As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: ___________________________________ Relationship to you: __________________

Minor's Date of Birth: _________________ Age: _______ Home Phone _________________________

Reason for which release is intended: La Escuela Familiar

Address of Minor: ______________________________________ City: ___________________________

Emergency Contact: ________________________________ Relationship to Minor:________________

Phone(s): ____

Family Physician: ________________________________Phone: _________________________________

Physician Address: ______________________________________ City: ___________________________

List allergies, medications, contacts, or other pertinent comments:

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Health Insurance Data:

Company: _______________________________________ Policy: _______________________________

Group: ____________________________ Contract: ____

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: ___________________ Signed: ____

(Parent or Guardian)

RM: MEDAUTH.2/04