SAINT PETER CATHOLIC SCHOOL STUDENT INFORMATION FORM

2022-2023

This form must be returned to St. Peter School by the end of the first week of school. This information is essential in providing adequate treatment for your child in case of illness or injury while at school. If your child requires prescription medication during school hours, a MEDICATION AUTHORIZATION FORM AND DOCTOR’S NOTE MUST BE TURNED INTO THE OFFICE. Thank you.

**STUDENT’S FULL NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Grade**\_\_\_\_\_\_\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_

 Mom’s e-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dad’s e-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FATHER’S NAME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WK. PH.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL PH.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MOTHER’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**HOME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WK. PH.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL PH.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you need to receive double mailings?\_\_\_Yes\_\_\_No**

**If yes, please be sure to indicate separate mailing addresses above.**

**ALTERNATE PERSON TO CONTACT FOR SICK CHILD PICK UP IF PARENT UNAVAILABLE**

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DAYTIME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DAYTIME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle if your child has any of the following:**

**ALLERGIES / ASTHMA / DIABETES/ SEIZURE DISORDER/ HEART PROBLEMS/ BEE OR ANT ALLERGY**

**FOOD ALLERGIES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child require an EPI-Pen? \_\_\_\_\_Yes\_\_\_\_No**

**Inhaler?\_\_\_\_\_\_Yes\_\_\_\_\_\_No**

**Please note: We do not provide over the counter medication.**