Dar-ul-Qur'an Full Time Hifdth Registration Form

TO PARENTS: Please fill out the registration form, sign, and date in blue or black ink.

Student Name _____ Male _____ Female _____
Last Name *First* *Middle*

Date of Birth _____ Place of Birth _____ Grade_____ Lives with: Both Parents Mother Father Guardian
Circle one

_____ Home Phone _____
Street Address (Primary Residence) City State Zip code area code + number

_____ Student Cell _____
Mailing Address, if different from above City State Zip code area code + number

Mother/Guardian Name _____ Home Phone _____
Last Name *First* area code + number

_____ Cell Phone _____
Street Address if different from above City State Zip code area code + number

Employer _____ Work Phone _____ Email _____

Father/Guardian Name _____ Home Phone _____
Last Name *First* area code + number

_____ Cell Phone _____
Street Address if different from above City State Zip code area code + number

Employer _____ Work Phone _____ Email _____

Parent/ Guardian Signature _____ Date _____

STUDENT EMERGENCY CONTACT CARD

Emergency Contacts/Medical Consent

In case of an emergency, it is imperative that the school be able to reach the student's parent or guardian. Please fill in the information on this card carefully and accurately. Please type or use ink and print clearly and legibly.

Student Name _____ **Birthdate** _____ **Gender** _____

Address _____ **SSN #** _____

Mother's Name _____ **Father's Name** _____

Primary Contact # _____ **Secondary Contact #** _____

AUTHORIZED CONTACTS: Please list the names of relatives/neighbors/friends in close proximity to the school to whom we may release your child ro contact if you cannot be reached. NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PARENTS, GUARDIANS OR ADULTS LISTED ON THIS CARD. In selecting someone to whom you authorize the release of your child, consider: Is this person prepared to handle any special medical needs required by your child?

I/We hereby authorize the release of the student named above to the following persons in the event of illness, injury, evacuation or emergency that may occur while students are in school.

Name	Relationship	Home Phone	Work/Cell Phone
			W
			C
			W
			C
			W
			C

I declare that the information on this form is true and correct. I will notify the school immediately of any changes to be made in the foregoing information.

Parent/Guardian Signature _____ Date _____ Relationship _____

Student Emergency Contact Card

Medical Information and Consent

STUDENT_____

MEDICAL/HEALTH INFORMATION

Medication: Does your child require medication? **YES** **NO**

If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name. An "Authorization for Administration of Medication" form must be on file.

Medication	Dosage	Hour(s) given

Health Insurance Information:

Health Plan/Group Name _____ Policy No. _____

Physician/Health Care Provider _____ Phone _____

Dentist _____ Phone _____

Vision or Hearing Problems:

Wears/glasses/contacts: for board work for reading all the time

Date of last eye exam _____ Wears hearing aid(s) _____

Medical Conditions: Please circle if your child has any of the following:

Severe allergies requiring: Epi-pen Benadryl

Food/ Environmental Allergies Stinging Insects/Bees Medicines/Drugs Other

Please explain: _____

Emergency Treatment Authorization

I/we, the undersigned parent(s) or legal guardian of _____, a minor, do hereby give authorization and consent to the school to obtain emergency medical care and necessary transportation, including x-ray examination, anesthetic, medical or surgical diagnosis and emergency hospital which is deemed advisable by and is to be rendered under the general or specific supervision of medical and emergency room staff licensed under the provisions of the medicine practice act and the State of Missouri Department of Public Health.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the student, but that any of the above treatment will not be withheld if the undersigned or authorized adults cannot be reached.

_____ is the hospital I/we prefer for emergency medical treatment of my/our child.

I/we understand that the school does not provide accident/medical insurance for students, and I/we further understand that all costs related to medical treatment may be my/our responsibility and not that of the school.

_____

Parent/Guardian Signature

_____

Date

Current asthma _____ If “Yes”, circle Uses Inhaler On Daily Medication

Current seizures _____ If “Yes”, on Medication YES NO

Diabetes _____ If “Yes” , Insulin Dependent YES NO

Behavior Problems: _____

_____

Movement Limitations: _____

_____

Other (please explain): _____

_____

Medical condition which might require care or accommodation at school (please describe):

_____

_____

PLEASE ATTACH FRONT AND BACK COPY OF YOUR INSURANCE CARD

VOLUNTEER ASSISTANCE

If you live close to school and feel that, if called, you can offer volunteer assistance during an emergency, please provide your name, phone number and expertise.

I would like to help in an emergency.

_____

Name

_____

Phone number

_____

_____

Qualifications