MALDEN COMM. CONS. SCHOOL DIST. #84
Malden, IL 61337

Student(s) **Full Name**: 1._____ Birth Date:_____ Grade:_____
2._____ Birth Date:_____ Grade:_____
3._____ Birth Date:_____ Grade:_____
4._____ Birth Date:_____ Grade:_____

Home Address:_____
_____ Phone:_____
_____

Mother's or Guardian's Name:_____ Phone:_____ Cell:_____
Address:_____
Work/Business Name/Address:_____ Phone:_____
_____

Father's or Guardian's Name:_____ Phone:_____ Cell:_____
Address:_____
Work/Business Name/Address:_____ Phone:_____
_____

IN CASE OF AN EMERGENCY WHEN THE PARENT OR GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:

Name:_____ Relationship:_____ Phone:_____
Address:_____

Name:_____ Relationship:_____ Phone:_____
Address:_____

Name:_____ Relationship:_____ Phone:_____
Address:_____

Family Physician:_____ Hospital:_____
Address:_____ Address:_____
_____ _____
Phone: _____ Phone:_____

PLEASE COMMENT ON ANY HEALTH PROBLEMS YOUR CHILD MIGHT HAVE:

IF WE OR THE AUTHORIZED PHYSICIAN NAMED ABOVE CANNOT BE REACHED IN CASE OF AN EMERGENCY OR TREATMENT IS URGENT IN THE JUDGEMENT OF THE SCHOOL, WE HEREBY AUTHORIZE AND DIRECT THE SCHOOL TO SEEK TREATMENT FOR OUR CHILD AT THE NEAREST HOSPITAL OR PHYSICIAN'S OFFICE.

_____ _____
Signature of Parent or Guardian Date