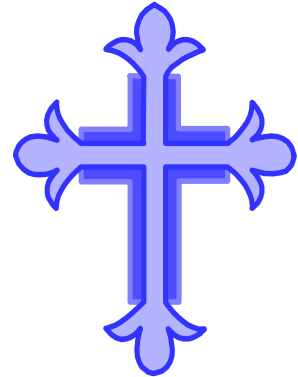


**Holy Rosary School**  
 161 9<sup>th</sup> Street Idaho Falls, ID 83404  
 (208) 522-7781  
 Please complete all blanks.

## Registration Form



Child centered, Christ driven

Child's Name	
SS#	
Birthday	
Sex / Race	/
Grade	
Religion	
Parish	
Baptism Date	
Child's Address	
City/State/Zip	
Home Phone	
Neighborhood School	

Father's Name	
Address	
City/State/Zip	
Home Phone	
Cell Phone	
Work Phone	

Mother's Name	
Address	
City/State/Zip	
Home Phone	
Cell Phone	
Work Phone	

e-mail:	e-mail:
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Please list at least one person for emergency contact. We would also like a list of people that are allowed to pick-up your child(ren).

	Name	Pick-up (Y/N)	Emergency Contact(Y/N)	Address	Phone	Relationship
Contact #1						
Contact #2						
Contact #3						
Contact #4						

The following person/s **may not** pick up my child(ren):

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**Medical Information**

<b>Physician/Pediatrician</b>	<b>Phone</b>	<b>Dentist</b>	<b>Phone</b>

I understand that Holy Rosary School does not assume responsibility for payment of a physician. However, in an emergency, the school may call the physician listed or choose a physician if the one listed is not available.

**Initial:** \_\_\_\_\_

List any medical conditions your child has: \_\_\_\_\_

\_\_\_\_\_

List any dietary need or restriction your child has: \_\_\_\_\_

\_\_\_\_\_

Prescribed Medications: \_\_\_\_\_

Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

My child may be given the recommended dose of: (check & initial to give permission)

Acetaminophen \_\_\_\_\_ and/or Ibuprofen \_\_\_\_\_

Parent Initials \_\_\_\_\_

The above information is accurate, to the best of my knowledge.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**