JUNCTION ELEMENTARY SCHOOL DISTRICT
RAIDER CARE PROGRAM ENROLLMENT FORM

Student Enrollment and Billing Info:

Student's Name:_________________________________ DOB:___________

Physical Address:____

Mailing Address:____

Parent/Guardian:________________________ Email:_________________

Place of Employment:___________________ Phone:__________________

Parent/Guardian:________________________ Email:_________________

Place of Employment:___________________ Phone:__________________

Billing Email:___________________________ Billing Phone:____________

Allergies or Health Concerns:_____________________________________

Primary Physician:______________________ Phone Number:___________

Additional Emergency Contacts:

Name: __________________________ Phone:______________________

Relationship:________________________ Authorized to Pick Up? YES or NO

Name: __________________________ Phone:______________________

Relationship:________________________ Authorized to Pick Up? YES or NO

Name: __________________________ Phone:______________________

Relationship:________________________ Authorized to Pick Up? YES or NO

I ACKNOWLEDGE THAT I HAVE READ, REVIEWED AND UNDERSTOOD THE RAIDER CARE PROGRAM HANDBOOK AND AGREE TO ABIDE BY ALL POLICIES.

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PARENT/GUARDIAN SIGNATURE **DATE**

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As legal custodian of _____________________, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to initiate paramedic/ambulance care or transport for said minor and to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Junction Elementary School District, its employees and its Board assume no liability of any nature in relation to the transportation or treatment of the said minor. I further understand that all cost of paramedic/ambulance transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my responsibility.

I understand that the Junction Elementary School District does not provide medical insurance for student injuries, but does offer student accident/health insurance for voluntary purchase. I have received the information and application for this program.

PERMISSION FOR EMERGENCY CARE

If I cannot be reached at my home or work number, contact any of the following individuals:

1. Name: ________________________Phone:_______________ Relationship:_________
2. Name: ________________________Phone:_______________ Relationship:_________
3. Name: ________________________Phone:_______________ Relationship:_________

In the event of an emergency, you have my permission to attempt to obtain treatment from:

Physician: ________________________ Phone: _________________

OR any physician by the school who will provide treatment.

SPECIAL INFORMATION

If your child has any of the following health concerns, please circle or state:

Hemophilia Allergy:___________ Asthma

Heat Seizures Diabetes

Emotional Tuberculosis Nosebleeds

Chronic Dizziness Sensitivity to Certain Drugs*

Other: ________________________

*Please Note: Junction School Staff cannot administer medication to your child without a Medication Release Form signed by doctor and parent.

I have read, reviewed, and understood the above information, and believe it to be true and correct.

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Parent/Guardian Signature **Printed Name** **Date**