



Pre-School Student Addendum

DAYTON CHRISTIAN SCHOOL SYSTEM
9391 Washington Church Road, Miamisburg, OH 45342
(937) 291-7212 Fax: (937) 291-7213 www.DaytonChristian.com

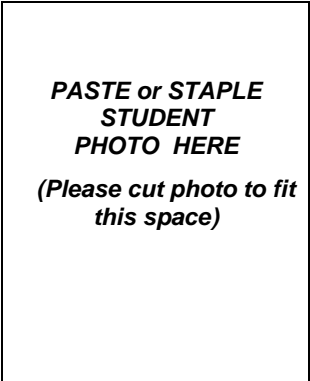
HOME PHONE # (_____) _____

1. _____
Student's Full LEGAL Name NAME Student goes by Date of Birth Grade School Desired
2. Gender: Male Female
3. Ethnicity: White/Non-Hispanic Black/Non-Hispanic Hispanic Asian/Pacific Islander American Indian/Alaskan Native Multi-Racial
4. Please select one: Morning Afternoon Full-Day
5. Please select one 3-Day 5-Day

6. _____
Father/Guardian LAST NAME / First Name / M.I. Mother/Guardian LAST NAME / First Name / M.I.
7. Is this child living with his/her custodial father? Yes No or with his/her custodial mother? Yes No
If you answered "No" to either, please explain: _____

8. AUTHORIZED PERSONS to assume responsibility to pick up from school.

1. _____ Phone _____ Cell _____
Home address _____ City _____ Zip _____
Work place _____ Phone _____ ext _____
2. _____ Phone _____ cell _____
Home address _____ City _____ Zip _____
Work place _____ Phone _____ ext _____



9. EMERGENCY CONTACTS to assume responsibility for the care of the child when parent, guardian or authorized person cannot be reached.

3. _____ Phone _____ cell _____
Home address _____ City _____ Zip _____
Work place _____ Phone _____
ext _____
4. _____ Phone _____ cell _____
Home address _____ City _____ Zip _____
Work place _____ Phone _____ ext _____

10. This student has a current physicians report which is a signed document reporting the examination of the child within twelve month prior to the date of the start of school .

Physician _____ Date of the exam _____

1. CONSENT FOR EMERGENCY TRANSPORTATION AND MEDICAL TREATMENT: In the event my/our child needs to be transported by ambulance or emergency vehicle, I/we authorize transportation.

In the event reasonable attempts to contact me/us have been unsuccessful, I/we hereby give my/our consent for administration of any treatment deemed necessary by Dr. _____ (preferred doctor) or Dr. _____, (preferred dentist); or, in the event the designated practitioner is not available, by another doctor or dentist; and the transfer of the child to any reasonably accessible hospital. This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

SIGNATURE OF PARENTS/GUARDIANS _____ **Date** _____
_____ **Date** _____

2. REFUSAL OF CONSENT NOTE: Do NOT complete Part 2 if you have completed Part 1. I/we do not give my/our consent for emergency medical treatment or emergency transportation of my/our child. In the event of illness or injury requiring emergency treatment, I/we wish the school authorities to take no action, or to:

SIGNATURE OF PARENTS/GUARDIANS _____ **Date** _____
_____ **Date** _____