FRIEND DAY SIGN-UP

A. STUDENT(S) INFORMATION *(please fill in and check the blanks that apply)*

STUDENT: ____________________

Legal Surname *Legal Given Names (First and Middle)* *Preferred Given Name*

ADDRESS: ____________________

CITY: __________ PROVINCE: __________ POSTAL CODE: __________

HOME PHONE:__________ GENDER: ❒Male ❒Female

PRESENT SCHOOL: ____________________

MEDICAL PROBLEMS: ❒Yes ❒ No If Yes, Explain:__________

Asthma? ❒Yes ❒ No Does your child carry an inhaler? ❒ No ❒Yes (self-medicating) ❒Yes, requires help

Food restrictions? ❒Yes ❒ No If Yes, Explain:__________

Allergies? ❒Yes ❒ No If Yes, What Type?__________

Symptoms of Allergies: __________

Carry an Epi-pen? ❒Yes ❒ No

ALBERTA HEALTH CARE #: __________

B. FAMILY INFORMATION

PARENT/GUARDIAN #1: ____________________

Legal Surname *Legal Given Names (First and Middle)*

RELATIONSHIP TO STUDENT: __________

CELL PHONE: __________ WORK PHONE: __________

EMAIL: __________

PARENT/GUARDIAN #1: ____________________

Legal Surname *Legal Given Names (First and Middle)*

RELATIONSHIP TO STUDENT: __________

CELL PHONE: __________ WORK PHONE: __________

EMAIL: __________

EMERGENCY CONTACT #1:__________ RELATIONSHIP TO STUDENT: __________

ADDRESS: __________

HOME PHONE: __________ CELL PHONE: __________

EMERGENCY CONTACT #1:__________ RELATIONSHIP TO STUDENT: __________

ADDRESS: __________

HOME PHONE: __________ CELL PHONE: __________