

**FIRST METHODIST SCHOOL  
MASTER CARD**

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

	<b>Mother</b>	<b>Father</b>
Name		
Address		
Employer		
Home Phone #		
Work Phone #		
Cellular Phone #		
Pager #		
E-Mail Address		

Person's with whom child lives: \_\_\_\_\_

Child's Doctor \_\_\_\_\_ Doctor's Phone Number \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Dentist's Phone Number \_\_\_\_\_

**Individuals to contact in case of emergency:**

Name	Phone Number

Does your child have any food allergies? Yes No Please List: \_\_\_\_\_

Does your child have any allergies? Yes No Please List: \_\_\_\_\_

Does your child have any dietary restrictions? Yes No Please List: \_\_\_\_\_

**MY CHILD HAS MY PERMISSION TO BE RELEASED TO THE FOLLOWING INDIVIDUALS IN ADDITION TO EMERGENCY CONTACT PERSONS LISTED ABOVE. (Please notify these individuals that they may be asked to show proof of identity.)**

Name	Relationship

I authorize First Methodist School to care for my child during the time he/she is in the facility or participating in a facility sponsored field trip and to administer and/or obtain emergency medical treatment for my child in the event that I cannot be reached.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>	<b>Date of Admission:</b> _____
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