Presidio School

After School Student Registration Form

TO BE COMPLETED BY PRESIDIO SCHOOL

Aftercare Registration Complete & Received By: _____

Registration Fee Received By: _____

Date: _____

Student Information:

Last Name: _____ First Name: _____ MI: _____

Home Address (#,Street,City,State,Zip Code): _____

Student Birth Date: _____

Does The Student Have A Medical Condition?(Please Explain): _____

Does The Student Take Prescription Medicine?(Please Explain): _____

Parent/Guardian Information:

With whom does the student currently live?(Mother,Father,Relative,Friend,Group Home,Etc): _____

Parent/Guardian Information:

- First Name: _____ Last Name: _____

Relationship: _____

Home Address (#,Street,City,State,Zip Code): _____

Cell Phone: _____ Work: _____ Ext. _____ Home: _____

- First Name: _____ Last Name: _____

Relationship: _____

Home Address (#,Street,City,State,Zip Code): _____

Cell Phone: _____ Work: _____ Ext. _____ Home: _____

Emergency Contact Information (Other than parent/guardian):

First Name: _____ Last Name: _____

Relationship: _____

Cell Phone: _____ Work: _____ Ext. _____ Home: _____

CDC/SGH # or name_____

ARIZONA DEPARTMENT OF HEALTH SERVICES

Arizona Department of Health Services
Bureau of Child Care Licensing
Emergency, Information and Immunization Record Card

Child's Name	Date Enrolled:	Updated:
Home Address: (#, Street, City, State, Zip Code)		Date Disenrolled:
Home Phone:	Date of Birth:	Sex: ☐ Male ☐ Female

Parent/Guardian Name:	Home Address: (#, Street, City, State, Zip Code)
Cell Phone: (optional)	Contact Phone number:

Parent/Guardian Name:	Home Address: (#, Street, City, State, Zip Code)
Cell Phone: (optional)	Contact Phone number:

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted:
(Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	Contact Phone number:
Name:	Contact Phone number:
Name:	Contact Phone number:
Name:	Contact Phone number:

If Medical care is necessary, call:

Health Care Provider*	Name:	Contact Phone number:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

In case of an injury or sudden illness, I request this individual be called first:	

The following individual(s) may **NOT** remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ Yes ☐ No

Telephone Authorization Code (Optional) _____

Immunization Information

(A licensee shall attached an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information, and Immunization record card.)

For information regarding the current immunization requirements, please visit:
www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630

One of these items must accompany the EIIR card at all times:

☐	Copy of current official documented immunization record attached
☐	Religious Beliefs exemption form signed by parent/guardian attached
☐	Medical Exemption form signed by physician and parent/ guardian attached
☐	Signed Laboratory Proof of Immunity form attached.

Notification of immunizations needed sent to Parent/Guardian(s):	Mo/Day/ Yr	Mo/Day/ Yr	Mo/Day/ Yr
Updated immunizations received and attached:	Mo/Day/ Yr	Mo/Day/ Yr	Mo/Day/ Yr

Medical Information

Is child allergic to food or other substances? If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	☐ NO ☐ YES
Is child usually susceptible to infections and if so, what precautions need to be taken? If yes, list precautions:	☐ NO ☐ YES
Is child subject to convulsions and what should be our procedure if one occurs? If yes, specify procedure:	☐ NO ☐ YES
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.) If yes, list precautions:	☐ NO ☐ YES
Additional Comments:	
Other Special Instructions:	

This Emergency Information and Immunization Record Card is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	SIGNED Name:	DATE: