

Please fill out the information below and return it to Skopos Christian School before your student begins classes. Thank you!

Student's First Name:	Middle Initial/Name:	Last Name:
Parents' Name(s):		Primary Contact Phone Number:
Name of primary care physician:		Physician's Phone Number:
Insurance Provider for Student:	Policy Number:	Name of Primary Cardholder:
Does the student have any ongoing medical conditions? If yes, please explain:		
Does the student have any known allergies, including food allergies? If yes, please list:		
In case of emergency, if parents are unreachable, please contact (in order):		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

In case of emergency, I authorize Skopos Christian School staff and volunteers to seek medical help on behalf of my child.

Parent Signature

Date