# PSR Registration Form

**Student Name (Last, First)**: _____

**Parents/Guardian**: Mother: _____ Father: _____

**Address**: _____

**Birthdate**: _____

**Phone**: Mother- Home: _____ Cell: _____ Work: _____

Father- Home: _____ Cell: _____ Work: _____

**(2) Emergency Contacts**:

Name: _____ Relationship: _____

Address: _____

Phone Number: Home: _____ Work: _____ Cell: _____

Name: _____ Relationship: _____

Address: _____

Phone Number: Home: _____ Work: _____ Cell: _____

**Does the student have siblings enrolled in PSR? If yes, please list names**:

_____

_____

**Health information** which PSR should know about student, including any medication information, and wishes for handling any physical/medical emergency:

_____

_____

_____

In case of accident or serious illness, I request the PSR to contact me. If the school is unable to reach me, I hereby authorize the PSR to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the PSR may follow my instructions above or make whatever arrangements seem necessary.

_____ _____

Signature of Parent or Guardian Date

**Local Physician:** _____ _____ _____

Name Phone: Office Emergency

**Emergency Center/Hospital** _____

**Address:** _____