CLARKSTOWN CENTRAL SCHOOL DISTRICT HEALTH SERVICES

COMPLETE THE FORM BELOW AND RETURN TO
THE COMMUNITY LEARNING CENTER 9 Lake Road, Congers, NY 10920

MAD Science

Pupil's Name__________________________________**Date of Birth**____________

Address______________________________________**Phone**________________

School___________________________**Grade**_______**Teacher**_______________

Name of Father_________________________________

Business Address________________________________**Bus. Phone #**____________

Name of Mother_________________________________

Business Address________________________________**Bus. Phone #**____________

Names of LOCAL persons to call in case of EMERGENGY, if you are not available:

____**Phone #**_______________

____**Phone #**_______________

____**Phone #**_______________

Your Child's Physician____________________________**Phone #**_______________

Your Child's Dentist______________________________**Phone #**_______________

Any other pertinent information regarding the health of your child you might wish to add:

____

Known Allergies:____

Epi-pen?:____

Other Medications:____

Name of person(s) who will pick up if you are not available:_______________________

____

__________________ ______________________________________

Date **Signature of Parent/Guardian**

Form #43 **A**