



**C.A.P.S. Tutorial Application
2019
Student Information**

_____ MI Age
Last Name First Name

_____ Zip Code
Street Address City

_____ Grade/Age
Home Phone Emergency Phone School

Known Illnesses _____

School Information

_____ Math Level
Teacher Reading Level

Area(s) of Weakness _____

Parent/Guardian Information

_____ MI
Last Name First Name

_____ Other
Home Phone Work/Emergency/Contact Phone

Parent(s) Email Address _____

***All Sections Must Be Filled Out
It is very important all information is current.
Signing this form also gives us permission to photograph your child for publication of brochures and
videos.***

EMERGENCY CONTACT FORM

Participant's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

Number(s) to call in emergency: _____

Parent/Guardian place of employment: _____

Address: _____

Work number: _____ Family Doctor: _____ Phone: _____

Address: _____

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital by car or ambulance for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, transport my child to _____.

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage is as follows:

Check all that apply:

- No medication of any type whether prescription or nonprescription may be administered to my child.
- No medication of any type whether prescription or nonprescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.
- I hereby grant permission for nonprescription medication to be given to my child if they become ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea such as aspirin, throat lozenges, and cough syrup.

Special Medical Information:

Allergic reactions (medications, foods, plants, insects, etc.): _____

Vaccinations/Shots are up to date: Yes _____ No _____

Most recent date of Tetanus Shot: _____

You should be aware of these known medical conditions of my child. _____

Signature _____ Date _____

*Please make sure that all information is current.
Tutorial Opens September 9, 2019*