

## C.A.P.S. Tutorial Application 2018 Student Information

Last Name	First Name		MI Age
Street Address	City		Zip Code
Home Phone	Emergency Phone	School	Grade/Age
Known Illnesses	School Information	on .	
Teacher	Reading Level Math Level		evel
Area(s) of Weakness			
	Parent/Guardian Infor	mation	
Last Name	First Name		MI
Home Phone	Work/Emerge	ency/Contact Phone	Other
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**

Partici	pant's Name:		Date of Birth:		
Parent	t/Guardian Name:				
Addre	ss:				
Numb	er(s) to call in emergency:				
Parent	t/Guardian place of employ	ment:			
Addre	ss:				
Work	number:	Family Doctor:	Phone:		
Addre	 SS:				
my chi advise transp <b>Medic</b> necess for se follow <b>Checl</b>	ild to a hospital by car or and prior to any further treated prior to any further treated to the content my child to ations: My child is taking sary, and such medications eing that the child takes sax:  **Content is a content in the content is a content in the child takes say:  **Content is a content in the cont	In the event of an emergency, mbulance for emergency med atment by the hospital or domestic medication at present. My will be well labeled. Names such medications, including does whether prescription or no	lical or surgical treatment. I octor. In the event of an ector. In the event of an ector in the event of medications and concise dosage and frequency of dotto in the event in the event of the event in the event in the event in the event of the event in the event of an event in the event in the event of an event in the event i	wish to be emergency, nedications directions osage is as nistered to	
	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.				
	al Medical Information: ic reactions (medications, fo	oods, plants, insects, etc.):			
Vaccin	ations/Shots are up to date	e: Yes	No		
Most r	recent date of Tetanus Shot:				
You sh	ould be aware of these kno	wn medical conditions of my	child.		
Signat	ure		Date		