SB Family School
2018-19 Math Groups
Registration Form

Child's Information:

Name:_____ Gender:_____ Age:_____ Birth Date:_____

Grade:____ School: _____ Email Address (ONLY IF DIFFERENT FROM PARENT'S):_____

Current Math Class: _____ Cell Phone Number (ONLY IF CHILD HAS OWN PHONE):_____

Parents' Information:

Mom's Name:_____ Dad's Name:_____

Street Address:_____ _____

Home Phone Number: _____ Mom's Cell: _____ Dad's Cell:_____

Mom's Email Address:_____ Dad's Email Address:_____

Medical Information

All medical information is confidential.

Does your child have allergies or any other medical conditions I should know about? ☐ Yes ☐ No

If yes, please describe: _____

Child's Physician: Name:_____ Address: _____ Phone Number:_____

Emergency Information

Please list an emergency contact: (*not yourself nor your spouse, someone else, in case you can't be reached*)

Name: _____ Relationship to Child: _____ Phone Number(s): _____

List the full names of others who have permission to pick up your child: _____

_____

Does your child have permission to walk home or wait alone to be picked up? ☐ Yes ☐ No

Authorization of Photographs of Child

Do you authorize SB Family School to use your child's image in photos or videos for the purpose of promoting SB Family School and its programs? ☐ Yes ☐ No ☐ Only with pre-approval of specific photo[s]

Authorization to Consent to Treatment of a Minor

I (We), the undersigned, parent(s) or guardian(s) of _____ a minor, do hereby authorize SB Family School, as agents of the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the California Medical Practice Act, whether such diagnosis or treatment is rendered during a SB Family School meeting by said health care provider at the meeting location, the provider's office, a hospital, or other location. The authorization also applies to dental care under a duly licensed dentist. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the afore mentioned physician in the exercise of his/her best judgment may deem advisable; and neither said agent or any organization involved assumes any financial responsibility for exercising this action. The undersigned also releases SB Family School, and its agent, from all claims which may develop or accrue to me, or the minor for whom this authorization is intended to benefit, on account of, or reason by of, any injury, loss, or damage which may be suffered by me or the minor as a result of the exercise of this consent, and I hereby assume and accept the full risk and danger of any injury; hurt or damage that may occur as a result of the use of exercise of this consent.

Mom's Signature: _____ Date: _____

Dad's Signature: _____ Date: _____