## JUNCTION ELEMENTARY SCHOOL DISTRICT RAIDER CARE PROGRAM ENROLLMENT FORM

## **Student Enrollment and Billing Info:**

Student's Name:	Grade: DOB:		
Physical Address:			
Mailing Address:			
Parent/Guardian:	Email:		
Place of Employment:	Phone:		
Parent/Guardian:	Email:		
Place of Employment:	Phone:		
Billing Email:	Billing Phone:		
Allergies or Health Concerns:			
Primary Physician:	Phone Number:		
<u>Additiona</u>	ll Emergency Contacts:		
Name:	Phone:		
Relationship:	Authorized to Pick Up?	YES or NO	
Name:	Phone:		
Relationship:	Authorized to Pick Up?	YES or NO	
Name:	Phone:		
Relationship:	Authorized to Pick Up?	YES or NO	
	ced up by someone 18 years of age or older, rent/guardian on file with RaiderCARE.	or must have a	
	READ AND UNDERSTOOD THE RAI AND AGREE TO ABIDE BY ALL POLIC		
PARENT/GUARDIAN SIGN	NATURE	DATE	

## <u>AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT</u>

Emotional Tuberculosis Nosek Other:  *Please Note: Junction School Staff Medication Release Form signed by I have read, reviewed, and und true and correct.	f cannot administer medicat y a doctor and parent.	· ·
Emotional Tuberculosis Nosel Other:*Please Note: Junction School Staff Medication Release Form signed by	f cannot administer medicat y a doctor and parent.	· ·
Emotional Tuberculosis Nosel	— Official Dizzmess	
Homophilia Allorgy	Asthma Hea	t Seizures Diabetes Sensitivity to Certain Drugs*
If your child has any of the following	_	
	_	
Physician:OR any physician by the school who		
In the event of an emergency, you h	ave my permission to attemp	
3. Name:		
2. Name:		
1. Name:	•	_
<b>PERMIS</b> If I cannot be reached at my home of	SION FOR EMERGENCY	
have received the information and a	ppucation for this program.	
for student injuries, but does offer s	•	• •
I understand that the Junction Elen	-	-
this authorization shall be my respo	•	
transportation, hospitalization, and		•
treatment of the said minor. I further	· · · · · · · · · · · · · · · · · · ·	
employees, and its Board assume no		
This authorization shall remain effe delivered to said agent(s). I underst		_
dentist may deem necessary.	ative for the full asked were	unless verrelred in remiting and
consent to any and all such diagnos	is, treatment, or hospital car	e which a licensed physician or
hospital care and provides authority		
I understand that this authorization	is given in advance of any re	equired diagnosis, treatment, or
		· •
rendered to said minor upon the ad	surgical diagnosis treatmen	
examination, anesthetic, medical or		Justin to any A-ray,
The state of the s	sport for said minor and to co	