

PPS-ENROLLMENT INFORMATION FORM/EMERGENCY CONTACT

* _____ STUDENT'S Name	* _____ M F Date of Birth Sex
* _____ OTHER NAME(S) USED	* _____ Name of High School/Graduation year
*() _____ () _____ Home Phone Work Phone	() _____ () _____ Home Phone Work Phone
* _____ Address (No P O BOXES)	* _____ Email address
* _____ City, ST ZIP Code	* _____ City, ST ZIP Code

Emergency Contacts

* _____ Primary Emergency Contact	* _____ Secondary Emergency Contact
*() _____ () _____ Home Phone Work Phone	() _____ () _____ Home Phone Work Phone
* _____ Address	* _____ Address
* _____ City, ST ZIP Code	* _____ City, ST ZIP Code

Medical Information

* _____ Hospital/Clinic Preference	
* _____ Physician's Name	* _____ Phone Number
* _____ Insurance Company	* _____ Policy Number
* _____ Allergies/Special Health Considerations	
I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for _____ and waive my right to informed consent of treatment. This waiver applies only in the event that no emergency contact primary or secondary can be reached in the case of an emergency.	
* _____ Print Name	* _____ Date
* _____ Signature	* _____ Date
* _____ Witness Signature	* _____ Date

information required to complete enrollment