

OLMC C.A.R.E.S. Program Registration for 2025-2026

Student's Name _____

Start Date: _____

Homeroom: _____

Gender: ☐ Male ☐ Female

Does your child take medication
on a daily basis? ☐ Yes ☐ No
List daily medications:

Drug/Food Allergies:

MOTHER

FATHER

Name: _____

Address: _____

City, State, Zip: _____

Home #: _____

Mobile #: _____

Work #: _____ Ext. _____

Email: _____

Name: _____

Address: _____

City, State, Zip: _____

Home #: _____

Mobile #: _____

Work #: _____ Ext. _____

Email: _____

Local Emergency Contacts And Authorized Pick Up Persons Other Than Parents (must be 18 years or older)

Name			
Home #			
Mobile #			

Medical Provider

Physician _____

Address _____

Phone _____

Insurance _____

Group/Plan # _____

Parent's **Full Signature** is required for each item below to indicate parental consent. Please sign each line individually.

Obtaining Emergency Medical Care _____ Transport to Hospital _____

Administer Minor First Aid _____ Photographs _____

Non-weather emergency plan: (**please check one**): ☐ Parent / Adult Pick-Up ☐ Bus ☐ Walker

I, the parent/guardian: received/agree to the complete written program information/policies at the time of enrollment

agree to update the emergency contact/parental consent form information whenever changes occur

Signature Parent/Guardian _____ Date _____