



Bishop McVinney School

155 Gordon Avenue Providence RI, 02905 OFFICE: 401-781-2370 FAX: 401-785-2618

Registration & Emergency Information | Summer 2019

Grade 2019-2020:

Student's Name: _____ D.O.B. _____ Male Female

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Father's Name: _____ Work Phone: _____

Mother's Name: _____ Work Phone: _____

Medical Information

*All medications will be held in the office; no child may carry any medication on their person.

*All medication must be clearly labeled and identified.

I give my permission for the school/daycare designee to administer medication.

Allergies: _____

Medication(s): _____

Special Needs: _____

Restrictions: _____

*In case of emergency or illness while parent is unavailable, the following persons are to be contacted:

1. Name: _____ 2. Name: _____

Phone #: _____ Phone #: _____

Relation: _____ Relation: _____

Signature - Sign-In/Out Information

* I hereby give permission for the following individual(s) to sign my child(ren) in/out from the school/day care program. I understand that if an individual's name does not appear on this form, they are not authorized to pick-up my child(ren). Only listed names below will be granted release.

These individuals must be ready to present their Driver's License or appropriate picture ID upon request.

1. Name: _____ Relation to child: _____

2. Name: _____ Relation to child: _____

3. Name: _____ Relation to child: _____

****PLEASE list anyone who is NOT authorized to pick up your child(ren)****

1. Name: _____ Relation to child: _____

2. Name: _____ Relation to child: _____

Parent(s) Signature: _____ Date: _____