Arkansas School for the Deaf
Transportation Registration Details
2020-2021

Student No	Last Name	First Name	Grade	Sex	Birth Date	Age	Phone

Address

Guardianship	

Emergency Contacts					
Name	Relation	E-mail	Home	Mobile	Work

Forms	Completed
Authorization to Treat	☐
Residency Information – McKinney Vento E-signature of Parent/Guardian/Unattached Youth **By signing below I acknowledge that I have received and understand the above rights.	☐
Consent for Release b/t School and Hospital – General	☐
Medication Authorization	☐
Photo and Video Release Form	☐
FERPA Consent Form	☐

AUTHORIZATION FOR ADMINISTRATION OF MEDICAL AND/OR EMERGENCY TREATMENT

During the course of study at the Arkansas School for the Deaf, unforeseen circumstances may arise that necessitate the administration of medical and/or emergency treatment upon the child. I, therefore, authorize and request that should I be unavailable for purposes of granting permission for such treatment, officials of the Arkansas School for the Deaf shall provide for such medical and/or emergency procedures as are necessary and desirable in the best judgment of the medical profession.

☐ I agree with the above statement.

Parent/Guardian Information	
Parent/Guardian 1 Name:	
Phone number:	
Workplace:	Work phone:

Parent/Guardian 2 Name:	
Phone number:	
Workplace:	Work phone:

Student Information

Will this student be a dorm resident at ASD? ☐ Yes ☐ No

Emergency Medical Treatment

Permission is given to the Arkansas School for the Deaf and its Staff to take necessary steps, medical and otherwise, for my child. This permission includes the administering of prescription drugs as well as the use of emergency medical facilities in the area where the emergency occurs.

IMPORTANT: Please list all the student's allergies (e.g., food, drug). If none, please write "none."

Name of the student's physician:

Insurance provider:

Policy/Medicaid number:

Student's local school district:

Does your child have court restrictions regarding a parent/legal guardian contact? ☐ Yes ☐ No

Student Transportation

Student will travel to school by (check one): ☐ Local district ☐ Charter bus ☐ Parent/Guardian ☐ Drive self

Student will travel from school by (check one): ☐ Local district ☐ Charter bus ☐ Parent/Guardian ☐ Drive self

☐ I give permission for my child to be transported by ASD staff members in school vehicles to and from ASD for field trips and other sanctioned activities.

☐ I authorize ASD to drop off and leave my child at his/her charter bus stop without supervision (only for students age 14 or older).

☐ I agree to pick up my child when contacted by a school administrator due to illness, behavior concerns, or other circumstances.

Please list below names and contact information of person(s) other than parent/guardian, permitted to take your child off campus or pick up from the weekend charter bus stop; you must contact the dorm supervisor or school secretary via email, text, fax, telephone or personal note advising who will take the child and when to expect that person.

Name:	Name:
Relationship to student:	Relationship to student:
Phone number:	Phone number:
Name:	Name:
Relationship to student:	Relationship to student:
Phone number:	Phone number:

Parent/Guardian Signature _____ Date _____