STUDENT INFORMATION AND CONSENT FORM
TO BE COMPLETED BY PARENTS

Please complete and return both forms with $125 check made payable to Creighton Prep

STUDENT’S NAME:____________________________________________________________

PARENTS’ or GUARDIANS’
NAMES:______________________________________________________________________

CELL PHONE#: (Area Code)____-____-_______

WORK OR DAYTIME PHONE#: (Area Code)____-____-_______

PHYSICIAN’S NAME:__________________________________________________________

PHYSICIANS PHONE #: (Area Code)____-____-_______

NAME AND TELEPHONE NUMBER OF PERSON TO BE CALLED IN EMERGENCY
(in case parents cannot be reached):______________________________________________

PHONE #: (Area Code)____-____-_______

HEALTH HISTORY

Does your child have allergies? Yes______ No_______
To what?____________________________________________________________________

Describe allergic reaction:____________________________________________________

___________________________________________________________________________

Any special problems of which we should be aware?________________________________

____________________________________________________________________________

Are there any sports activities in which he cannot participate? Yes_____ No_____
If yes, please describe:_______________________________________________________

____________________________________________________________________________

In the event that my consent is not readily obtainable, permission is hereby given to the officials of
Creighton Preparatory School to authorize such medical treatment, including an emergency operation, as
they may be advised is necessary for my son. I realize that the financial responsibility for such treatment
or surgery is mine.

___________________________________    ___________________
(Parent’s Signature)         (Date)