



INTERNATIONAL STUDENT PHYSICIAN RELEASE FORM

Student's Personal Information

Name: _____
First Name Middle Name Last Name

Male Female Date of Birth: _____ Place of Birth: _____

Country of Citizenship: _____

Primary International Address: _____
Street City State/Province Postal Code

Primary International Phone Number: _____ Home Cell Work

Primary U.S. Address: _____
Street City State Zip

Primary U.S. Phone Number: _____ Home Cell Work

Family Information

Parent Information	MOTHER	FATHER
Name		
Address (if different than previously stated)		
Primary Phone (if different than previously stated)		
Cell Phone		
Work Phone		
Primary E-mail Address		
Occupation		
Name of Business		
Legal Guardian Information Student Resides With in U.S.	FEMALE	MALE
Name		
Address (if different than previously stated)		
Primary Phone (if different than previously stated)		
Cell Phone		
Work Phone		
Primary E-mail Address		
Occupation		
Name of Business		
Relationship to Student		



Student Health Information

Health Insurance Provider: _____

Policy Holder Name: _____

Policy Number: _____ Agreement Number: _____

The applicant does does not have hospitalization coverage

Applicant's medical history or problems (e.g. allergies, diabetes, color blindness, convulsive disorders, and serum sensitives): _____

Applicant's current medications: _____

Emergency Contact Information

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Emergency Dismissal Information

In case of illness, or emergency early dismissal due to inclement weather or any unforeseen circumstances, please release the above named student to:

A Ride the bus home

B Pick up by authorized person: _____

Name

Phone Number

Physician's Release

The above named child has been examined and I certify that he/she may participate in physical education class, swim class, and athletic activities.

Name of Physician: _____

Signature of Physician: _____

Date: _____



Providence Heights
ALPHA SCHOOL
Where tradition meets new heights of excellence

In the event of an emergency and the parents/guardians/emergency contacts can not be reached, the undersigned hereby authorizes representatives of Providence Heights Alpha School to act as my agent to secure emergency medical treatment for the above named student, a minor child for whom I am responsible, at UPMC Passavant Hospital, when, in the opinion of school representatives, such emergency medical treatment is deemed appropriate during the time my child is attending, coming to, or leaving school. I hereby agree to hold Providence Heights Alpha School, its representatives, and the Sisters of Divine Providence harmless for exercising its judgment in authorizing such emergency treatment and said representatives specifically authorized to sign any required emergency hospital treatment forms on my behalf.

In consideration for the above named student being permitted to participate in physical education class, swim class, and athletic activities, I do hereby release and forever discharge Providence Heights Alpha School and the Sisters of Divine Providence located at 9000 Babcock Boulevard, Allison Park, PA, 15101 from any and all actions or suits in law or equity which I might hereafter have, by reasons of injuries sustained by the above named student participating in physical education class, swim class, or athletic activities.

I/We, the undersigned, do attest to the accuracy of the information provided on this form. Furthermore, should there be any change, I/we will immediately notify the school's Principal.

Parent/Guardian Name

Parent/Guardian Signature

Parent Guardian Name

Parent Guardian Signature

Date