



THE BUCKNER FANNING CHRISTIAN SCHOOL

**STUDENT CHANGE OF INFORMATION**

PLEASE PRINT

Name \_\_\_\_\_

Last

First

Middle

**PLEASE ONLY FILL OUT THE INFORMATION BELOW THAT HAS CHANGED**

Home Address \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Mother's Cell \_\_\_\_\_

Father's Cell \_\_\_\_\_

Mother's e-mail \_\_\_\_\_ @ \_\_\_\_\_

Father's e-mail \_\_\_\_\_ @ \_\_\_\_\_

Spouse \_\_\_\_\_

*Name*

*Home*

*Cell*

*Office*

Friend/Neighbor \_\_\_\_\_

*Name*

*Home*

*Cell*

*Office*

**RELEASE: In case of emergency, accident, or serious illness to me in which medical treatment is required and Buckner Fanning Christian School (the school) can not reach any of the above contacts, my signature below authorizes the school to exercise their own judgment in contacting the physician indicated below and to follow his/her instructions. If this physician is unavailable, the school may make whatever arrangements are necessary or transport the employee to a hospital emergency room.**

\_\_\_\_\_  
*Signature* *Date Signed*

Do you have any major or unusual health conditions that we should be aware of?  Yes  No

If yes, please specify. \_\_\_\_\_

Local Physician's Name \_\_\_\_\_ Address \_\_\_\_\_

Office Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_