

Child's Name: Last _____ First _____ Middle _____

Address _____
Street Town State Zip

Home Tel. # _____ Sex _____ Date of Birth ____/____/____ Soc. Sec. # _____

Optional, for the purpose of government data only and NOT used as consideration for admissions (check one)

- African American
- Caucasian
- Hispanic/Latino
- Asian
- Other _____

Name of child's physician _____ Office phone # _____

Physician's Address _____

List any allergies, special dietary needs or medical conditions _____

Does your child have any handicaps or illnesses (physical and/or emotional), which may affect their activities or progress and which should be made known to their teacher? _____

Is your child on any prescription medication? Yes No If yes, please complete the following info:

Name of medication	When administered	Reason for medication
_____	_____	_____
_____	_____	_____

Medical Ins. Co. _____ Policy # _____ Tel. # _____

Has your child ever been given a psychological, behavioral or learning disabilities test? _____

In the event of a medical emergency, in order of priority, please list person to contact.

Name of Person	Relationship to Student	Tel. #
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

List the names of other persons you authorize to pick up your child. Please note that your child will only be released to the persons listed below. Any changes must be reported immediately to the school's main office.

Name of Person	Relationship to Student	Tel. #
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

