School Year_____ **Student Contact Information** Revised 7/01/09 2009-10
Student # _____ **Use Blue or Black Ink** Please complete all blanks

Basic Student Information

SOP 8.18a

Last Name _____ First Name_____Middle_____ Other_____
Sex_____ Date of Birth_____ Age_____ Birthplace (City and State)_____
School_____ Grade_____ Social Security Number_____
Transferred From_____Address_____
911 Address_____
_____City_____State/Zip_____
Mailing Address
_____
_____City_____State/Zip_____
Student Home Phone #_____Listed or Unlisted
Transported by Bus _____Yes or _____No Bus # AM _____ PM _____ Special Medical Need_____
List siblings_____
Is the home language English _____Yes or _____No Native Language_____ Hispanic? (Y/N)_____
Race Options (check all that apply): White____ Black____ Asian____ Amerind____ Pacific____

Parent/Guardian Information

Last Name_____First Name_____Middle_____Relationship_____
911 Address Home Phone# _____Cell Phone# _____Pager #_____
_____E-Mail_____
_____City_____State/Zip_____
Mailing Address
_____
_____City_____State/Zip_____
Employer_____ Work Phone #_____ Ext_____
Occupation_____ Cell #_____ Ext_____
Pager #_____ Ext_____E-Mail _____
Is a translator needed to communicate with parent/guardian? _____Yes _____No

2nd Parent/Guardian Information

Last Name_____First Name_____Middle_____Relationship_____
911 Address Home Phone # _____Cell Phone #_____Pager #_____
_____E-Mail_____
_____City_____State/Zip_____
Mailing Address
_____
_____City_____State/Zip_____
Employer_____ Work Phone #_____ Ext_____
Occupation_____ Cell #_____ Ext_____
Pager #_____ Ext_____E-Mail _____

Emergency Contact Information – Other than a Parent/Guardian for Immediate Pickup from School

Last Name_____First Name_____Middle_____ Title_____Relationship_____
911 Address
_____E-Mail_____
_____City_____State/Zip_____
Mailing Address
_____
_____City_____State/Zip_____
Day Time Phone #_____ Cell Phone #_____Pager #_____

This questionnaire in this section is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information will help determine the services the student may be eligible to receive.
1. Is your current address a temporary living arrangement? ____ Yes ____No
2. Is this temporary living arrangement due to loss of housing or economic hardship? ____Yes ____No

– School Use Only –
CR or
HR Teacher _____
Date entered into
the computer _____

_____ _____ _____
Print Name of Parent/Guardian Signature of Parent/Guardian Date

Copies to: Principal – Teacher – Health Nurse – Transportation Department – Attendance Director

School Year_____ **Student Contact Information** Revised 7/01/09 2009-10
Student # _____ **Use Blue or Black Ink** Please complete all blanks

SOP 8.18b

Student_____ School _____

In case my child becomes seriously ill or injured at school take my child to _____. The physician and the hospital are hereby authorized to render such treatment as may be deemed necessary in an emergency for the health of my child.

_____ _____
Print Name of Parent/Guardian Signature of Parent/Guardian

_____ _____ _____ _____ _____
Home Phone # Work Phone # Cell Phone # Pager # E-Mail Address

Name of Physician_____ Phone #_____
Physician's Address_____

Does the above student have any of the following?

Description	Yes	No	Explanation	Medication/Dosage
1. Heart Defect				
2. Diabetes				
3. Convulsive/Seizure Disorder				
4. Cerebral Palsy				
5. Visual Impairment				
a. Corrective Glasses				
7. Hearing Impairment				
a. Hearing Aid				
8. Orthopaedic Impairment				
a. Wears Prosthesis				
9. Scoliosis				
10. Behavioral Disorders				
11. Urinary Tract Disorders				
12. Gastro/Intestinal Disorder				
13. Asthma				
14. Allergies				
a. Seasonal				
b. Food				
c. Bee Sting				
15. Nasal/Respiratory Disorder				
16. Limited Activities				
17. Premature Birth				
18. Other				

Special Instructions:

– School Use Only –

HR Teacher _____

Date entered into the computer _____

_____ _____ _____
Print Name of Parent/Guardian Signature of Parent/Legal Guardian Date

Copies to: Principal – Teacher – Health Nurse – Department Transportation

_____ _____ _____
Print Name of Parent/Guardian Signature of Parent/Guardian Date

Copies to: Principal – Teacher – Health Nurse – Transportation Department – Attendance Director