

NAME: _____
Last First Middle

Sex: Male:
Female:

Legal Last Name (if different): _____ Birthday: _____ Home Phone: _____

Address: _____ Apt.: _____ City: _____ ZIP: _____

List below parent(s) or guardian child lives with:

Name: _____ Relationship to Child: _____ Employer: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____ E-mail: _____

Name: _____ Relationship to Child: _____ Employer: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____ E-mail: _____

If parents are divorced or separated, who has physical custody? Parents should notify the district immediately if there is a change.

Joint Mother Father Guardian

Day Care: Name _____ Phone: _____

In case of illness, emergency or accident and parent/guardian cannot be located; the following adults are authorized to act on behalf of the parent/guardian.

Please enter two names of local neighbors, friends, relatives, or sitter.)

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

Physician's Name: _____ Medical Coverage by: _____ ID#: _____

Address _____ Physician Phone No.: _____ Hospital Preference: _____

**Must
Check
One**

1.

In the event of an emergency, when a parent or guardian is unavailable, I authorize School personnel to make arrangements for my child to receive medical/hospital care including necessary transportation, in accordance with their best judgment. I authorize the physician named above to undertake such care and treatment as is considered necessary. In the event said physician is unavailable, I authorize such care and treatment to be performed by a licensed physician or surgeon. I agree to pay all costs incurred as a result of the foregoing

2.

I do not choose the above statement and desire the following action in the event of an emergency:

I understand that the information contained herein will be made part of this child's computerized school record.

Parent / Guardian Signature

Date

Parent / Guardian Signature

Date

QDA

PLEASE CHECK THE FOLLOWING IF THEY PERTAIN TO YOUR CHILD

CHECK HERE IF THERE ARE NO KNOWN HEALTH PROBLEMS

EYES

Wears Glasses To be worn at all times

Wears Contacts To be worn at all times

Requires preferential seating _____ Date of last eye examination: _____

Under care of Dr. _____

Phone: _____

Comments: _____

EARS

Has a hearing problem Has tubes in ears Uses hearing aid

Requires preferential seating

Under care of Dr. _____

Phone: _____

Comments: _____

BROTHERS AND SISTERS

	NAME	SCHOOL ATTENDING	GRADE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

QDA

PLEASE CHECK THE FOLLOWING IF THEY PERTAIN TO YOUR CHILD

GENERAL HEALTH

Has the following condition(s):

Epilepsy Fainting Spells Diabetes

Hyperactive (ADHD/ADD) Heart Condition Migraines

Asthma

Other: _____

Are any of the above life threatening? Yes No Please explain: _____

Allergies (please describe): _____

Allergic reaction to bee stings (please describe): _____

Other: _____

List medication(s) prescribed: _____

Current Dosage: _____

For (diagnosis): _____

Does the drug need to be taken during school hours? NO YES

If yes, a medication administration form **must** be completed)

Prescribed by Dr. _____

Has physical condition which limits participation in:

Classroom Activities Physical Education

Please Explain: _____

Under the care of Dr. _____ Phone: _____

Date of last tetanus shot: _____