Reedsville School District

STUDENT INFORMATION SHEET

Please fill out and bring to homeroom by September 6.

Student's Full Name: _____ Social Security #: _____ Gender: _____ Grade: _____

Birthdate: _____ Home Phone: _____ (W-White/A-Asian/B-Black/H-Hispanic/I-Indian: _____

Birth City: _____ Birth County: _____ Birth State: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Student's E-mail: _____

Father: _____ Father's Workplace: _____ Father's Day Phone: _____

E-mail Address: _____ Father's Cell Phone: _____

Mother: _____ Mother's Workplace: _____ Mother's Day Phone: _____

E-mail Address: _____ Mother's Cell Phone: _____

Step Parent: _____ Step's Workplace: _____ Step's Day Phone: _____

Step's Cell Phone: _____

Is there a second parent or legal guardian who would like to receive school mailings? If yes, please list:

Name: _____

Mailing Address: _____

With whom does the child reside? _____ Who has custody? _____

Relationship to the child? _____

Emergency Contact Information

List three people who will assume temporary care of your child if you cannot be reached at home or at work. They can be reached during school hours at the number listed.

Emergency Contact #1: _____ Relationship: _____ Daytime Phone: _____

Emergency Contact #2: _____ Relationship: _____ Daytime Phone: _____

Emergency Contact #3: _____ Relationship: _____ Daytime Phone: _____

Student's Emergency/Health Information

In case of accident or serious illness, I request the school to contact me. If unable to reach me, I hereby authorize the school to call the physician indicated below or make whatever arrangements seem necessary.

List any medical conditions the school should be aware of: _____

_____

Does your child require medication at school? If so, stop in the office to pick up a Medication Consent Form with Physician's Order for Administration and return to office.

Doctor's Name: _____ Doctor's Clinic: _____ Doctor's Phone: _____

Dentist's Name: _____ Dental Clinic: _____ Dentist's Phone: _____

Signature of Parent/Guardian: _____ Date: _____