PLEASE FILL OUT BOTH SIDES. PARENT/GUARDIAN SIGNATURE MUST BE ON FILE FOR ALL STUDENTS.

2016 Student Information Form

Port Washington Saukville School District Summer School

Student _____ **Birthdate** _____
(Last) (First) (Middle Initial) (Month) (Day) (Year)

2016-17 Grade _____ **School District of Residence** _____

2016-17 School _____
(Address if outside of Port Washington Saukville School District)

Ethnic Classification (circle one): White Black Hispanic Asian American Indian

Home Address _____
(Street or P.O.) (City) (State) (Zip)

Home Phone No. _____ **Gender:** Male Female **Primary Language** _____

Student lives with (circle all that apply): Mother Father Other_____

Parent/Guardian Information (circle one): Mother Step-Mother Guardian Other _____

Name_____ Home Phone _____ Cell Phone _____

Address (if different from student) _____

E-mail Address _____ Employer _____

Work Days _____ Work Hours _____ Work Phone _____

Parent/Guardian Information (circle one): Father Step-Father Guardian Other _____

Name _____ Home Phone _____ Cell Phone _____

Address (if different from student) _____

E-mail Address _____ Employer _____

Work Days _____ Work Hours _____ Work Phone _____

Emergency Information

Doctor's Name _____ Phone: _____

Dentist's Name _____ Phone: _____

If emergency treatment is required and the parents cannot be reached immediately, may the school authorities use their own judgment in calling the doctor or dentist you have identified? (Check one) Yes _____ No _____

If your dentist or doctor is not available, do you give school officials the authority to seek treatment from another doctor/dentist? (Check One) Yes _____ No_____

If your answer is "no" to either of these questions, what do the parent(s)/guardian(s) want done in case of an emergency?

_____

Contact Information: Please list 3 adults who may be called in an emergency and who may pick up your child, if you cannot be reached.

1. Name _____ Relationship to Student _____
   Daytime Phone No. _____ Cell Phone _____
2. Name _____ Relationship to Student _____
   Daytime Phone No. _____ Cell Phone _____
3. Name _____ Relationship to Student _____
   Daytime Phone No. _____ Cell Phone _____

PLEASE COMPLETE AND SIGN THE REVERSE SIDE OF THIS FORM.

Your child will not be scheduled for classes until this completed and signed form is on file.

CURRENT HEALTH INFORMATION

DOES YOUR CHILD HAVE:

(Please check YES for each item and if yes, indicate specific information that will help school personnel meet your child's health and educational needs).

YES

_____ ADD/ADHD

_____ ASTHMA Specify: _____

_____ Does your child require an inhaler at school?_____

_____ DIABETES: _____

_____ Will your child be checking BS and receiving insulin at school? _____

_____ EPILEPSY OR SEIZURES Specify: _____

_____ HEART DISEASE that requires special care at school?_____

_____ ALLERGIES that require an Epi-Pen? _____

_____ Food Allergies/Dietary Restrictions: _____

_____ PHYSICAL HANDICAPS Specify:_____

_____ Medications that your child takes regularly:_____

_____ Medication taken during school hours? **(*)**

Specify:_____

ADDITIONAL INFORMATION YOU CARE TO SHARE:

_____

_____

(*) All medications, including inhalers and Epi-Pens, MUST be kept in the school office. If your child needs to carry their inhaler with him/her, you must have a Physician form on file in the office giving permission. A completed "Medication and Release Form" must be on file for any prescription or over-the-counter drugs to be administered by the school.

I understand that this information will be shared in a confidential manner with my child's teacher(s) and school personnel to best meet the health and education needs of my child.

_____ _____

(Signature of Parent/Guardian) (Dated)

If you have any health related questions regarding your child, please contact the School District Nurse at the District Office. She can be reached at 268-6000.