

**Schuylerville Central School District Student Contact and Health Information**

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_ Home Phone # \_\_\_\_\_

Mailing Address \_\_\_\_\_

Full name(s) of sibling(s) attending Schuylerville Schools \_\_\_\_\_

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Name of Mother/Guardian \_\_\_\_\_

Mailing Address \_\_\_\_\_

Home Phone # \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # or Beeper # \_\_\_\_\_

Home e-mail address \_\_\_\_\_ Work e-mail address \_\_\_\_\_

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Name of Father/Guardian \_\_\_\_\_

Mailing Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Caller ID? Y N (circle one)

Place of Employment \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # or Beeper # \_\_\_\_\_

Home e-mail address \_\_\_\_\_ Work e-mail address \_\_\_\_\_

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If there is a custody issue, who is the custodial parent/guardian? \_\_\_\_\_ Are papers on file at school? Y N (circle one)

If child does not reside with both parent(s)/guardian(s), with whom does he/she reside?

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

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If parent is unable to be reached, please provide names of two people who would be willing and available to assume responsibility for your child in the case of illness/injury:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # \_\_\_\_\_ E-mail address \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # \_\_\_\_\_ E-mail address \_\_\_\_\_

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Signature \_\_\_\_\_ Date \_\_\_\_\_

(Please turn card over for health data)

**Schuylerville Central School District Student Contact and Health Information**

Student's Name \_\_\_\_\_

Student's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have health insurance? \_\_\_\_\_

*Please list the following health information:*

Allergies \_\_\_\_\_

**Food allergies must be verified in writing by a doctor if food substitutions are required for meals prepared and purchased at school.**

Medication taken at home and/or school and reason for medication \_\_\_\_\_

Recent operations \_\_\_\_\_

Medical Conditions or recent illnesses \_\_\_\_\_

Disabilities \_\_\_\_\_

\_\_\_\_\_ Glasses      \_\_\_\_\_ For Near Vision Correction      \_\_\_\_\_ For Far Vision Correction

**Physician's and parent/guardian's written permission is required for any medication (including non-prescription medication) to be given at school. Medication must be transported to and from school **only** by parent or guardian or designated adult.**