

## Student Information 2009-2010

Last Name: _____		First Name: _____	
<input type="checkbox"/> Female	<input type="checkbox"/> Male	Age: _____ (as of 9/01/08)	Birth date: _____
Home Address: _____		City _____	State _____ Zip _____
Home Phone: _____		Day time phone: _____ (if we need to reach you during school hours)	

Parent's Marital Status:  Married/Partners  Divorced  Single Student's Residence:  Both  Parent 1  Parent 2  Guardian

Parent/Guardian 1: _____	Parent/Guardian 2: _____
Address: _____	Address: _____
Cell Phone: _____	Cell Phone: _____
Business Phone: _____	Business Phone: _____
E-mail: _____	E-mail: _____
Occupation: _____	Occupation: _____
Employer: _____	Employer: _____

Person(s) to call if we are unable to reach a parent or guardian that is listed above:		
Name: _____	Phone: _____	Relationship: _____
Name: _____	Phone: _____	Relationship: _____

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

<p>Allergies, please mark all that apply. Add others as needed.</p> <p><input type="checkbox"/> Peanuts <input type="checkbox"/> Tree nut <input type="checkbox"/> Milk Product (Casein Protein) <input type="checkbox"/> Egg <input type="checkbox"/> Soy <input type="checkbox"/> Gluten <input type="checkbox"/> Fish <input type="checkbox"/> Shellfish</p> <p>Other(s): _____</p> <p>Food restrictions, please mark all that apply. Add others as needed.</p> <p><input type="checkbox"/> Animal Fat <input type="checkbox"/> Beef <input type="checkbox"/> Poultry <input type="checkbox"/> Pork <input type="checkbox"/> Fish</p> <p>Other(s): _____</p> <p>Allergy related comments: _____</p> <p>Allergy management plan on file: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is your child taking any prescribed or over the counter medication(s) regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain:          _____</p> <p>Does your child have any vision or hearing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain: _____</p> <p>_____</p>
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\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date