



2010-2011

740 Maple Drive
St. Croix Falls, WI 54024



Student Information Form

School District of St. Croix Falls



Student's Name: _____ Phone: _____ Social Security: _____ Grade: ___ Ethnicity: ___

Birthdate: _____ Gender: ___ Check here ___ if you would like to receive email. Email Address: _____

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

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

Father: _____ Work Phone: _____ Home Phone: _____ Cell Phone: _____

Mother: _____ Work Phone: _____ Home Phone: _____ Cell Phone: _____

Place of Employment: Father _____ Mother _____

With whom does this child live with? _____ Teacher: _____

Brothers and sisters in school: Name: _____ Grade: _____ Name: _____ Grade: _____

Student's Health History

Hospital's Name: _____ Doctor's Name: _____ Doctor's Phone: _____

Dentist's Name: _____ Dentist's phone: _____

List any allergies or health concerns your child may have: _____

Does your child have visual problems? _____ Wears glasses/contacts full time _____ Wears glasses for reading only _____

Hearing Problems: _____ Ear Infections? _____ Tubes? _____ Hearing Aids? _____

Medications: List any medication your child takes at home either daily or occasionally. Must have written permission and medicine must be in the original container. Prescription medication must have physician's written order to be given at school. _____

It is the parent's responsibility to notify the school if the family changes telephone number, mailing address, etc. Names of relatives/neighbors who will care for your child if ill or in case of early dismissal: (Will be called if unable to reach parents at home or work.)

Name: _____ Phone: _____

Name: _____ Phone: _____

The data which you supply on this form will be used to contact you, or others you have named, in event of an illness or emergency of your child. Data provided will constitute a private record. It is your responsibility to make arrangements for proper care incase you child meets with an accident or becomes too ill to remain in school at a time when you are away from home. 1. Designate a neighbor or relative to care for your child in their home until you can be reached. 2. Arrange for a person to care for your child when parents or guardian work, or are routinely away from home, when it is necessary for the school to send the child home due to illness. The school will first call parents or guardian at home or at work, unless you state otherwise. 3. Provide for transportation home or to the doctor's office, if necessary.

CONSENT FOR MEDICAL CARE

To the extent health care services are provided to my minor child consistent with this consent, I agree to waive indemnify, and hold the facility(ies), its employees, agents, and representatives, harmless from any claim of failure to first obtain my permission to examine or treat my minor child. I hereby consent to allow any clinic and/or hospital, its staff, physicians, and surgeons to provide medical services to my minor child whose name is: _____

Medical Insurance Company: _____ **Policy #** _____

This consent is:

() Limited to emergency services only, under circumstances where the medical facility has been unable, in the exercise of due diligence or because of the nature of the emergency, to contact me or to contact me quickly enough to otherwise obtain my consent.

() A general consent is intended to allow the medical facility to examine or treat my minor child without first obtaining any additional consent.

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

Name: _____

Mailing address: _____ **Phone Number:** _____

Parent/Guardian Signature: _____ **Date:** _____

I have read the above statements, and I agree to supply the data on this card with full knowledge of the information in that statement. The School District of St. Croix Falls does not discriminate on the basis of age, sex, race, color, national origin, religion, ancestry, creed, pregnancy, marital or parental status, sexual orientation, or physical, mental, emotional, or learning disability, or handicap.