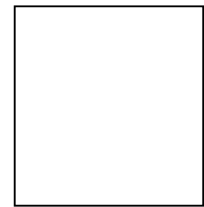
Student # ___________________________ Bus #_________



Teacher_____________________________

Medical Alert _____*Medication_________

Lakeside School Emergency/Enrollment Information

Student Last Name: ___________________________________ Student First Name:___________________________

Grade: ______ Birth date: _______________ Gender: M__ F__ Home Phone: ( ) _______________________________

Home Address:____Zip:__________

Mother/Guardian:____Employer:____________________________

Work Ph:____________________________Cell Phone:___________________ E-Mail:____________________________

Father/Guardian:____Employer:____________________________

Work Ph:____________________________Cell phone:___________________ E-Mail:____________________________

Child is living with*: Select one)* Both Parents Mother Father Guardian Foster Care

Emergency Contacts: (*if parent is not available call the following)*

Childcare provider____Phone:__________________

Name:_______________________________ Relationship_________________________Phone:__________________

Name:_______________________________ Relationship_________________________Phone:__________________

Name:_______________________________ Relationship_________________________Phone:__________________

Other children in home (name and school if any)

____ ____

____ ____

Where is your child and family currently living? (Check only one box*) This information will be used to determine if your child qualifies for any additional assistance under the No Child Left Behind Act of 2001.*

- □ **In a single family residence {200}**
- □ **In a foster care placement {190}**
- □ **In a shelter or transitional housing program {190}**
- □ **Unsheltered (car or campsite) {191}**
- □ **With more than one family in a house or apartment due to economic hardship or loss {191}**
- □ **Licensed Care Institution (group home) {190}**
- □ **Armed Forces Family Member {192}**

Have you moved within the past three (3) years, even for a short time? □Yes □ No

Was the move for a member of your family to find work in agriculture? [09] □Yes □ No

Medical Information

Is the student allergic to bee stings?_______Please list any other allergy or medical condition_________________________

____

My child's primary care physician is: Dr. ______________________________________Phone #______________________

Address ____

In case of an emergency, I understand my child will be transported to a medical facility as determined by emergency services personnel.

If school and/or medical personnel are unable to contact me, this is my permission for the attending medical personnel to administer the necessary first aid treatment. If the physician needs to use an anesthetic before treatment, this is my permission for him or her to do so. All of the above information is true to the best of my knowledge.

________________________________ ________________________________ ______________

Signature of Mother/Guardian Signature of Father/Guardian Date

Student Last Name:______________________

Student First Name:______________________