

Charlotte Central School
Student Information Sheet
PLEASE REVIEW / UPDATE THE INFORMATION BELOW

Student Name: _____ Gender: _____ DOB: // _____ GRD: _____ Team: _____ Tchr. _____

Bus Information: What are the Bus #'s: AM Bus: _____ AM Stop: _____ PM Bus: _____ PM Stop (for k's only): _____

Transportation Notes: _____

PARENT: _____ Relationship: _____ Custody: _____ Legal Guardian: _____ Can Pick Up: _____

Address: _____ PO Box: _____ Can Send Mailings: _____

Phn #1: _____ Ext: _____ Phn #2: _____ Ext: _____ Phn #3: _____ Ext: _____

Employer: _____ E-Mail: _____ Can Send E-Mail to: _____

SPOUSE: _____ Relationship: _____ Custody: _____ Legal Guardian: _____ Can Pick Up: _____

Address: _____ PO Box: _____

Phn #1: _____ Ext: _____ Phn #2: _____ Ext: _____ Phn #3: _____ Ext: _____

Employer: _____ E-Mail: _____ Can Send E-Mail to: _____

Parent @ Other Addr: _____ Relationship: _____ Custody: _____ Legal Guardian: _____ Can Pick Up: _____

Address: _____ PO Box: _____ Can Send Mailings: _____

Phn #1: _____ Ext: _____ Phn #2: _____ Ext: _____ Phn #3: _____ Ext: _____

Employer: _____ E-Mail: _____ Can Send E-Mail to: _____

Emergency #1: _____ Relationship: _____ Phn #1: _____ Ext: _____ Can Pick Up: _____

Emergency #2: _____ Relationship: _____ Phn #1: _____ Ext: _____ Can Pick Up: _____

Day Care: _____ Phn #1: _____ Ext: _____ Can Pick Up: _____

HEALTH INFORMATION:

Doctor's Name: _____ Doctor's Phn #: _____ Date of Last Physical: _____

Health Insurance Company Name: _____

List Child's Allergies: _____

In case of minor illness or injury, I hereby authorize school personnel to perform basic first aid including the use of over-the-counter medicines and comfort measures, at manufacturer's recommended dosages. Yes No

Parent's Signature (required): _____ Date: _____

Please read the following statement and sign for your permission

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school personnel to seek emergency medical care, including transportation to the emergency room. I hereby authorize the physician in charge to administer whatever emergency treatment is necessary at my expense.

Parent's Signature (required): _____ Date: _____

PLEASE RETURN THIS FORM TO THE MAIN OFFICE

Please notify the Main Office immediately if there are any changes to phone numbers, mailing addresses, e-mail addresses, emergency contact or any other information that will help the school staff to provide the best care possible to your child.

**** OVER ****

Charlotte Central School Health History

IMMUNIZATION RECORD: Has your child had any immunizations in the past year? If yes, please provide and updated immunization record.

EXEMPTION REQUESTED (*State Form Required*): ___ Medical ___ Philosophical ___ Religious
(If requesting exemption, please contact school nurse for proper form.)

List any medication that your child receives daily/regularly: _____

List any medication that your child will need to receive daily/regularly at school:
_____ Times to be administered: _____

SEPARATE FORM REQUIRED FOR ANY PRESCRIPTION MEDICINE TO BE GIVEN DURING SCHOOL

Has there been any serious illness or injury to immediate family members during the last year?

If yes, describe: _____

List any major accidents, injuries, illnesses or chronic problems your child has had, giving dates and treatment as appropriate: _____

Vision History

Date of last eye exam: _____ Doctor's Name: _____

Glasses ___ yes ___ no

Contact lenses ___ yes ___ no

Other eye problems, i.e. (muscle problem/injury/surgery) _____

Hearing History

Date of last hearing exam _____ Doctor's Name: _____

Hearing devices ___ yes ___ no

Ear tubes ___ yes ___ no

Other ear problems, i.e. (frequent infections/injury/surgery) _____

Oral Health History

Date of last dental exam: _____ Dentist: _____

Please indicate if your child has had any of the following and the date of when:

- ___ Measles ___ Anemia ___ Asthma ___ Rubella ___ Diabetes ___ Whooping Cough ___ Hepatitis
___ Epilepsy/Seizures ___ Chicken Pox ___ Mumps ___ Pneumonia ___ Hernia ___ Strep Throat ___ Bronchitis
___ Bladder Infection ___ Kidney Disease ___ Meningitis ___ Rheumatic Fever

Is there anything about your child's health that concerns you?

Signature of Parent/Guardian _____

Date _____