STUDENT DEMOGRAPHIC DATA VERIFICATION

PLEASANTS COUNTY SCHOOLS

School: _____

Please check the information below and make the corrections above the printed data. Return this form to your school's main office within two days. Thank you.

Name: _____ **Grade:** ____ **Student ID:** _____ **S.S.#:** _____

Birthdate: _____ **Gender (M/F):** ____ **Ethnicity (W B H A I):** ____ **Birthplace:** _____

Home Address: _____ **City, State Zip:** _____

Mailing Address: _____ **City, State Zip:** _____

Primary Contact: _____ **Relationship:** _____

Phone: _____ **Unlisted (Y/N):** __ **Cell:** _____ **Pager:** _____

E-mail Address: _____

Employer: _____ **Work Phone:** _____ **Ext.** _____

Secondary Contact: _____ **Relationship:** _____

Phone: _____ **Unlisted (Y/N):** __ **Cell:** _____ **Pager:** _____

E-mail Address: _____

Employer: _____ **Work Phone:** _____ **Ext.** _____

Emergency Information/Contacts:

Call Order	Title	Name	Relationship	Area Phone	Ext.
____	_____	_____	_____	_____	
____	_____	_____	_____	_____	
____	_____	_____	_____	_____	
____	_____	_____	_____	_____	

School and Bus Information:

Locker: _____ **Counselor:** _____ **Homeroom:** _____ **AM Bus:** ____ **PM Bus:** ____

Bus Stop Location: _____

Time Boarding Bus: _____ **a.m.**
Time Returning Home: _____ **p.m.**

Special Instructions (Please include any health problems/treatments):

_____

_____

_____

(Please Complete Back)

If early dismissal or sign out is necessary and unable to reach parents, list two neighbors or nearby relatives who will assume temporary care of your child:

1. Name _____ **Relationship** _____ **Phone** _____
2. Name _____ **Relationship** _____ **Phone** _____

Directions to home if P.O. Box or Route: _____

_____

Permission for school personnel to administer first aid? _____ **Yes** _____ **No**

In case my child becomes seriously ill or injured at school, and I or other people listed on this card cannot be reached, take my child to Dr. _____ **or to the** _____ **Hosipital Emergency Room. The school personnel, physician, Emergency Squad, and Hospital are hereby authorized to render such treatment as may be deemed necessary in an emergancy for the health of my child.**

_____
Parent/Guardian Signature

I do _____ **do not** _____ **have school insurance.**
I do _____ **do not** _____ **have other insurance/medical coverage. (Including Medicaid and CHIPS)**

Has your child ever been diagnosed by a doctor with any of the following:

_____ ADD/ADHD	_____ Eating Disorder	_____ Osgood-Schlaters Disease
_____ Arthritis	_____ Hearing Problem	_____ PMS/PMDD
_____ Asthma	_____ Heart Problem	_____ Repeated Ear Infection
_____ Bipolar	_____ Hemophilia	_____ Schizophrenia
_____ Cancer	_____ High Blood Pressure	_____ Scoliosis
_____ Cerebral Palsy	_____ Hormone Deficiency	_____ Seizures
_____ Crohns Disease	_____ Kidney/Renal Problem	_____ Substance Abuse
_____ Cystic Fibrosis	_____ Leukemia	_____ Tourette's
_____ Depression	_____ Multiple Sclerosis	_____ Ulcer
_____ Diabetes	_____ OCD/ODD	_____ Vision Problem other than Glasses

Need for Epi-pen (Y/N)? _____ **Does your child wear contact lens (Y?N)?** _____

Does your child wear a prosthesis (Y/N)? _____

List any activity restrictions: _____

List daily long-term medications: _____

Student will need special health care procedure at school (Y/N)? _____ **Descride procedure:**

_____

_____

Does your child have any severe reactions to bee stings requiring an injection or medication (Y/N)? _____

Does your child have any drug allergies (Y/N)? _____

If yes, list drugs:

_____ _____

_____ _____

_____ _____