

SPECIAL SCHOOL DISTRICT OF ST. LOUIS COUNTY
STUDENT ENROLLMENT/EMERGENCY CONTACT FORM
School Year _____

STUDENT DATA:

Name: _____ Student ID _____
Last First MI
Date of Birth: _____ Gender: Male / Female Race: _____
Student Address: _____
Street Number City/State Zip
Home District: _____ Attending School: _____

PARENT/LEGAL GUARDIAN #1 – First contact

Name: _____
Spouse/Partner: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Primary Language: _____
Email: _____
Employer's Name: _____ Work Phone: _____

PARENT/LEGAL GUARDIAN #2 – Second contact

Name: _____
Spouse/Partner: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Primary Language: _____
Email: _____
Employer's Name: _____ Work Phone: _____

FOR EMERGENCY USE WHEN PARENT CANNOT BE LOCATED: Persons listed below has your authorization to pick up your child.

FIRST EMERGENCY CONTACT

Name: _____
Relationship: _____
Phones: Home _____ Cell: _____ Work: _____

SECOND EMERGENCY CONTACT

Name: _____
Relationship: _____
Phones: Home _____ Cell: _____ Work: _____

1. Are you sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason?
 Y N Explain if it is a similar reason: _____
2. Are you currently residing at a motel, hotel, in a car, or at a campsite because your home has been damaged or because of economic reasons? Y N
3. Are you currently residing in a shelter? Y N
4. Are you currently living in a temporary housing arrangement due to economic hardship? Y N
5. Has a family member moved w/children in the last 3 years to seek temporary or seasonal agricultural or processing work? Y N

HEALTH CARE PROVIDERS

Family Physician: _____ Phone: _____
 Hospital: _____
 Insurance Plan: _____ Membership Number: _____
 Dentist: _____ Phone: _____

Health Information: To be completed by parent or guardian prior to entry into Special School District.

Does student have a history of: Asthma Diabetes Heart Condition Convulsive Disorder

Allergies List: _____

Medical Diagnosis: _____

Other Medical Concerns: _____

Medications: List all medications, give name(s) amounts and time medication is taken: _____

Does the student have Down Syndrome? _____ If yes, has a physician examined and x-rayed, including full flexion and full extension views, for Atlantoxial Subluxation? Yes _____ Date of x-ray _____

No x-ray taken _____ (Signed release from doctor must be provided)

Hearing Loss? Y N Hearing Aid(s) Y N Contact Lenses? Y N Glasses? Y N

Date of Last physical exam: _____ Date of Tetanus Booster: _____

EMERGENCY PROCEDURE: In case of injury or illness requiring medical care, you have my permission to obtain such care from the nearest hospital and to release personally identifiable information regarding my child. I agree to pay all expenses incurred in such emergency care.

Signature: _____ Date: _____