

STUDENT & PARENT INFORMATION FORM

SUMMER 2012



STUDENT INFORMATION			
Last Name:		First Name:	Middle Name:
Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height: Weight:
Eye Color:		Hair Color:	Skin Color:
Identifying Marks:			
Street Address:		Apt/Unit #:	City:
State:	Zip:	Primary Phone	
Race: <input type="checkbox"/> White, Not of Hispanic Origin <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other_____			
Country of Origin: _____ First language your child began to speak _____			
Primary language used in the home _____			
Church or Religious Affiliation, if any:			
PRIMARY HOUSEHOLD INFORMATION: Name of person(s) with whom student is living			
Living with: (Check One)	<input type="checkbox"/> Both Parents	<input type="checkbox"/> Father Only	<input type="checkbox"/> Mother Only
	<input type="checkbox"/> Relative	<input type="checkbox"/> Mother/Stepfather	<input type="checkbox"/> Father/Stepmother
FATHER'S INFO	Father's Name:		Email:
	Business Name & Address:		
	Work Title:		
	Home Phone:	Work Phone:	Cell Phone:
	Home address if different:		
	City:	State:	ZIP:
MOTHER'S INFO	Mother's Name:		Email:
	Business Name & Address:		
	Work Title:		
	Home Phone:	Work Phone:	Cell Phone:
	Home address if different:		
	City:	State:	ZIP:
LIST ALL OTHERS THAT LIVE IN THE HOME			
1.	Name:	Relationship:	
2.	Name:	Relationship:	
3.	Name:	Relationship:	
4.	Name:	Relationship:	
5.	Name:	Relationship:	

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MEDICAL & INSURANCE INFORMATION		
Date of Last Physical:	Doctor's Name :	Phone Number:
Insurance:	Policy/Group No:	Hospital(s):
ALLERGIES PLEASE LIST ANY MEDICAL CONDITIONS, ALLERGIES ETC.		
MEDICATION CONSENT FORM: I authorize staff members at Highrock Covenant Preschool, who are trained in the basics of First Aid, to administer medication to my child as described below by my child's physician. (Please provide Doctor's note)		
Prescription Medication	Medication Name:	
Dosage:	Date(s) Medication is to be given:	
Reasons for Medication:		
Possible Side Effects:	Storage Instructions:	
Non Prescription Medication (Provided by Parents)		
Medication Name:		
Dosage:	Date(s) Medication is to be given:	
Reasons for Medication:		
Possible Side Effects:	Storage Instructions:	
EMERGENCY CONTACT PERSON		
1.	Name:	Relationship:
	Home Phone:	Cell Phone:
2.	Name:	Relationship:
	Home Phone:	Cell Phone:
3.	Name:	Relationship:
	Home Phone:	Cell Phone:
PARENT/GUARDIAN SIGNATURE:		
Signature:		Date: