School:_____ Year: _____ Homeroom Teacher: _____

Transportation (B=Bus, C=Car) AM: PM: Custody Papers on file? Yes No

Caswell County Elementary Schools Student Data & Health Information Sheet

Please complete all requested information, sign and return form to school immediately.

Proof of residency and guardianship/custody papers are required prior to new enrollment.

Student's First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: Month:_____ Day:_____ Year: _____ Current Age:_____

Mailing Address:_____

_____ Phone: _____

911 Address:_____ Birthplace:_____

Please answer **both** the ethnicity **and** race categories. You may select more than one race option.

You must select one of these: Ethnicity: Hispanic/Latino Non-Hispanic/Latino

You must select at least one of these: Race: American Indian/Alaska Native Asian Black Hawaiian/Pacific White

Male Female

Student resides with: Mother Father Mother & Father Father & Stepmother Mother & Stepfather Guardian

Mother/Stepmother/Guardian:_____ Living Deceased

Employer:_____ Highest Grade Completed:_____ Birthplace:_____

Phone Number: Home:_____ Work: _____ Cell: _____

Email:_____

Mailing Address:_____

911 Address:_____

Father/Stepfather/Guardian:_____ Living Deceased

Employer:_____ Highest Grade Completed:_____ Birthplace:_____

Phone Number: Home:_____ Work: _____ Cell: _____

Email:_____

Mailing Address:_____

911 Address:_____

Siblings in the home: Brother(s) [name(s) & age(s)] _____

Sister(s) [name(s) & age(s)] _____

Parent's marital status: Married Separated Divorced Single

Does your child have a current IEP or 504? Yes No

Is your child under current suspension/expulsion from his/her previous school? Yes No

If yes, name and location of school:_____

Has your child ever attended a Caswell County School before? Yes No If yes, which school:_____

Is your child transferring from another school? Yes No If yes, which school:_____

Address_____ Phone:_____

Any other person(s) who has your permission to **pick up your child** if the parents cannot be reached? Include those with your permission to take child to doctor in the event of an emergency (List by priority):

Name:	Phone:
_____	_____
_____	_____
_____	_____

Any person(s) who should not have contact with your child (must provide legal documentation):

_____

In case of inclement weather/early dismissal your child should:

Go Home as usual Other: _____

Office use only: Entry code: _____ Student ID Number_____ Entry date_____

Student Health Inventory

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and return this to your child's school for review by the School Nurse.

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Orthodontist			
Case Worker (If applicable) / Counselor			
Hospital Preference			

Child's Health Insurance· None Medicaid Private/Commercial/Employer sponsored

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Head or spinal injury		
Aller11ies (seasonal)			Concussion w/in the last year		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Autism			Migraine Headaches		
Behavioral Problems			Muscle problems		
Bladder problem			Nose Bleeds		
Bleeding problem			Psychiatric & Emotional Difficulties		
Blood pressure (high)			Seizures		
Bone/Joint problems			Sickle Cell Disease		
Bowel problem {Stomach/Bowel)			Speech problems		
Cancer			Special Health Care Services		
Cerebral Palsy			Surgery		
Cystic fibrosis			Thyroid		
Dental problems			Vision problems		
Developmental problems			Other:		
Diabetes					

Current medications:

Name of medication	Dose	Home	School

I, _____ ***(do__) (do not_) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form.*** *This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's s'Chool. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian:_____***Date: __ /__ /__***

Signature of person completing this form:_____***Date: ___ /__ /_***