

School Year 2018 - 2019



Student and Family Information:

student photo
School provides

Student Name: _____

Grade: _____ D.O.B.: _____

Home Phone: _____

Student Address: _____

Student City/State/Zip: _____

Mother's/Guardian's Name: _____

Mother's/Guardian's Address: _____

Mother's/Guardian's City/State/Zip: _____

Mother's/Guardian's Home Phone: _____ Work Phone: _____

Mother's/Guardian's Cell Phone: _____

Mother's/Guardian's Email Home: _____

Mother's/Guardian's Email Work: _____

Father's/Guardian's Name: _____

Father's/Guardian's Address: _____

Father's/Guardian's City/State/Zip: _____

Father's/Guardian's Home Phone: _____ Work Phone: _____

Father's/Guardian's Cell Phone: _____

Father's/Guardian's Email Home: _____

Father's/Guardian's Email Work: _____

In case of emergency, if parents/guardians are not available, please contact (in this order):

Name: _____ Relationship: _____

Phone: _____ Phone: _____

Name: _____ Relationship: _____

Phone: _____ Phone: _____

These people are authorized to pick up my child from school (other than custodial parents):

Name: _____ Relationship: _____

Phone: _____ Phone: _____

Name: _____ Relationship: _____

Phone: _____ Phone: _____

****Blanket Permission Form for School-Sponsored Field Trips****

My child, _____, a student at Summit Academy of Greater Louisville,

has my/our permission to take all school-sponsored field trips.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Please list **ANY MEDICATIONS** taken at home and at school:

Name _____ To treat _____ Dosage _____ Time _____

Name _____ To treat _____ Dosage _____ Time _____

Name _____ To treat _____ Dosage _____ Time _____

Name _____ To treat _____ Dosage _____ Time _____

Allergies: (especially to food or medication) _____

Current Diagnoses/Medical Concerns: _____

Does/will your child receive speech therapy or occupational therapy services? (circle all that apply)

Speech Service Provider: _____ Hours/Week _____

OT Service Provider: _____ Hours/Week _____

Counseling Service Provider: _____ Hours/Week _____

Do you authorize Summit personnel to administer: Y/N Tylenol? _____ Ibuprofen? _____ Tums? _____

Hospital Preference in emergency: _____

Name of Doctor: _____ **Phone:** _____

Address: _____

Please list any other information which you feel would be pertinent in regard to accident, emergency, etc.

I/We, _____, the parent(s)/guardian(s) of Summit Academy of Greater Louisville student _____, **do hereby consent** that Summit Academy personnel may obtain emergency medical care for the above-named child at the expense of the parent or guardian, and release said personnel from any liability.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Family Information Update

Student's Name: _____ **Grade:** _____

Parent Info:	Father	Mother
Name:	_____	_____
Place of Employment:	_____	_____
Position/ Job Title:	_____	_____
Affiliations (Civic organizations, Board memberships, Other):	_____	_____
	_____	_____
	_____	_____

Parents: If you would like your child's grandparents to receive newsletters, event invitations, and other mailings, please complete the information below. Include email address, if applicable.

Paternal Grandfather

Name: _____

Address: _____

Email: _____

Maternal Grandfather

Name: _____

Address _____

Email: _____

Paternal Grandmother

Name: _____

Address (if different): _____

Email: _____

Maternal Grandmother

Name: _____

Address (if different) _____

Email: _____