

School Year 2022-2023



Student
Photo

School
Provides

Student Name: _____

Grade: _____ **DOB:** _____ **Gender:** _____

Primary Contact Phone: _____

Primary Address: _____

City/State/Zip: _____

Student race/ethnicity (select all that apply):

Asian or Pacific Islander

Black or African American

Hispanic or Latino

Native American or Alaskan Native

White or Caucasian

A race/ethnicity not listed here

Mother's/Guardian's Information:

Name: _____

Address (if different): _____

City/State/Zip: _____

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

Primary Email: _____

Father's/Guardian's Information:

Name: _____

Address (if different): _____

City/State/Zip: _____

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

Primary Email: _____

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

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Authorized to pick up (other than custodial parents and emergency contacts)

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

EMERGENCY/MEDICAL INFORMATION

Allergies:**Requires Emergency Medication:**Food: _____ Yes NoMedication: _____ Yes NoEnvironmental: _____ Yes No

* If "yes" was selected, provide emergency medication protocol with the "Permission to Administer Medication" form to the Office Manager.

Medications:Check any medications that you authorize Summit Academy personnel to administer: Tylenol Ibuprofen Benadryl Tums/Antacid NONEList any medications (prescription or OTC) routinely taken at home and/or at school:

Name: _____ Dosage: _____

Time(s) take: _____ Take for: _____

Name: _____ Dosage: _____

Time(s) take: _____ Take for: _____

Name: _____ Dosage: _____

Time(s) take: _____ Take for: _____

Name: _____ Dosage: _____

Time(s) take: _____ Take for: _____

* If your child takes additional medications, please write or type a list and attach.

Diagnoses:

List all medical diagnoses: _____

List any additional medical concerns: _____

Does your student have a history of seizures? yes no

* If "yes" was selected, provide seizure protocol to the Office Manager.

In case of emergency:

Preferred hospital: _____

Pediatrician Name: _____

Practice Name: _____ Phone number: _____

List any additional information you feel would be relevant in an accident or emergency:

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

Parent/Guardian Signature _____ Date: _____

Family Information Update

Students Name: _____ **Grade:** _____

Parent Information:

Mother's/Guardian's Name: _____

Place of Employment: _____ Position/Job Title: _____

Affiliations (civic organizations, board memberships, other): _____

Father's/Guardian's Name: _____

Place of Employment: _____ Position/Job Title: _____

Affiliations (civic organizations, board memberships, other): _____

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

Name: _____ Relationship to student _____

Address: _____

Email Address: _____

Name: _____ Relationship to student _____

Address: _____

Email Address: _____

Name: _____ Relationship to student _____

Address: _____

Email Address: _____

Name: _____ Relationship to student _____

Address: _____

Email Address: _____

Name: _____ Relationship to student _____

Address: _____

Email Address: _____