STUDENT INFORMATION

Last Name _____ **First** _____ **Middle** _____ **Grade** _____

Home Address _____

_____ **Home Phone** _____

Date of Birth _____ **Town of Birth** _____ **Gender** _____

Student Lives with _____

CONTACT INFORMATION

Parent /Legal Guardian #1 _____ **Home Phone** _____
Address _____ **Cell Phone** _____
_____ **Employer Name** _____
E-mail _____ **Employer Phone** _____

Relationship to Student _____

Parent /Legal Guardian #2 _____ **Home Phone** _____
Address _____ **Cell Phone** _____
_____ **Employer Name** _____
E-mail _____ **Employer Phone** _____

Relationship to Student _____

EMERGENCY CONTACTS

(Adults other than those listed above who are willing to assume temporary care of your child and who will be contacted if we are unable to contact a parent or guardian.)

1. **Full Name** _____ **Daytime Phone** _____
   Relationship _____ **Cell Phone** _____

2. **Full Name** _____ **Daytime Phone** _____

   Relationship _____ **Cell Phone** _____

3. **Full Name** _____ **Daytime Phone** _____
   Relationship _____ **Cell Phone** _____

Are there any restrictions regarding dismissals, visitations or information on your child? ☐ **Yes** ☐ **No**

If yes, explain _____

If there are legal restrictions for the school to observe, i.e. custody/guardianship orders or protection orders, Strong Foundations must be provided with the appropriate legal documentation.

STUDENT NAME _____ **GRADE** _____

MEDICAL HISTORY

Does the student have?

Asthma	Yes	No
Seizures	Yes	No
Diabetes	Yes	No
Hearing Problem	Yes	No
Vision Problems	Yes	No
IEP or 504 Plan	Yes	No

Does the student use?

Inhaler @ school	Yes	No
Epi-Pen for allergic reactions	Yes	No

ALLERGIES

Bees	Yes	No
Environmental	Yes	No
Seasonal	Yes	No
Food(s)	Yes	No
Medication(s)	Yes	No

List food(s) and/or medication(s) and type of reaction.

_____

_____

Please list current medications (if applicable):_____

_____

May we have permission to use/administer?

Refresh tears lubricant eye drop	Yes	No	Children's Sudafed/decongestant	Yes	No
Tylenol (pain or fever)	Yes	No	Antibiotic Ointment	Yes	No
Ibuprofen (pain)	Yes	No	Calamine Lotion	Yes	No
Tums (indigestion)	Yes	No	Antiseptic Cream	Yes	No
Cough Drops	Yes	No	Hydrocortisone Cream	Yes	No
Benadryl	Yes	No	Orajel for dental pain	Yes	No
Children's Cough & Cold	Yes	No			

WOULD YOU LIKE TO BE NOTIFIED IF WE ADMINISTER MEDICATION AT SCHOOL? Yes No

Should Strong Foundations be aware of any other medical problems or restrictions?

_____

_____

The State of New Hampshire requires parental permission and a doctor's order for students who need an Epi-Pen, inhaler or prescription medications while in school.

IF YOU INDICATE ABOVE THAT YOUR CHILD IS IN NEED OF AN EMERGENCY MEDICATION AT SCHOOL, WE WILL REQUIRE THESE BE MADE AVAILABLE TO US WITH A PHYSICIANS ORDER BY THE FIRST DAY OF SCHOOL

Doctor's Name _____ **Phone** _____

Dentist's Name _____ **Phone** _____

PERMISSION TO PROVIDE EMERGENCY TREATMENT

I hereby grant permission to Strong Foundations to administer First Aid, Epinephrine (Epi-Pen), if necessary, and secure proper emergency treatment for my child in the event a parent or legal guardian cannot be contacted.

_____ _____

Parent/Legal Guardian signature **Date**

PERMISSION TO CONTACT STUDENT'S DOCTOR

to confirm immunization and physical exam during the school year (August to June).

_____ _____

Parent/Legal Guardian signature **Date**

Name of Student's Doctor_____**Phone #:**_____**Fax #:**_____

I HAVE CONFIRMED ALL OF THE ABOVE INFORMATION CONCERNING MY CHILD AND WILL NOTIFY STRONG FOUNDATIONS CHARTER SCHOOL IMMEDIATELY OF ANY CHANGES.

_____ _____

Parent/Legal Guardian **Date**