School _______________________________________ Year ____________ Homeroom Teacher _________________________
Transportation (B = Bus, C = Car) AM________ PM ________ Bus # _______ Custody Papers on file? ☐ Yes ☐ No

Caswell County Elementary Schools Student Data & Health Information Sheet

Please complete all requested information (both sides of this sheet), 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: ________ Age ______________

Mailing Address ____ Phone _________________________

911 Address ____ Birthplace ___________________________

Both categories need to be completed. Please choose one for the **ethnicity** **AND** one or more for **race**:

Example: **Ethnicity**: ☐ Hispanic/Latino ☒ Non-Hispanic/Latino **Race:** ☐ American Indian/Alaska Native ☒ Asian ☐ Black ☐Hawaiian/Pacific ☒ White

1. **Ethnicity**: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
2. **Race**: ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐Hawaiian/Pacific ☐ White

Student's Social Security Number (Optional) ________________________________ ☐ Male ☐ Female

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

Mother/Stepmother/Guardian ____ ☐ Living ☐ Deceased

Employer _____________________________________Highest grade completed ___________ Birthplace _______________________

Phone number: Home __________________________ Work __________________________ Cell ______________________________

Mailing Address ____

911 Address ____

Father/Stepfather/Guardian ____ ☐ Living ☐ Deceased

Employer _____________________________________Highest grade completed ___________ Birthplace _______________________

Phone number: Home __________________________ Work __________________________ Cell ______________________________

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

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: School ____

Address ____ Phone ___________________

Is your child under current suspension/expulsion from his/her previous school? ☐ Yes ☐ No If yes, name and location of school:

____

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	Relationship	Phone Numbers		
___________________________	________________	Home _________________	Cell _________________	Work __________________
___________________________	________________	Home _________________	Cell _________________	Work __________________
___________________________	________________	Home _________________	Cell _________________	Work __________________

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: ____

Continue on Health Information - Over….

Office use only: Entry code __________________ NC Wise 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 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		
Allergies *(seasonal)*			Hearing problems or deafness		
Asthma or breathing problems			Heart problems		
Attention-Deficit/Hyperactivity Disorder			Migraine Headaches		
Autism			Muscle problems		
Behavioral problems			Nose Bleeds		
Bladder problem			Psychiatric & Emotional Difficulties		
Bleeding problem			Seizures		
Blood pressure *(high)*			Sickle Cell Disease		
Bone/Joint problems			Speech problems		
Bowel problem *(Stomach/Bowel)*			Special Health Care Services		
Cancer			Surgery		
Cerebral Palsy			Thyroid		
Cystic fibrosis			Vision problems		
Dental problems			Other:		
Developmental problems					
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 school. 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: _____/_____/_____*