School _____ Year _____ Homeroom Teacher _____
Transportation (B=Bus, C=Car) AM_____ PM _____ Custody Papers on file? ☐ Yes ☐ No

Caswell County 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 Last Name: _____ First Name: _____ Middle Name: _____ Suffix: _____

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 options.

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

You must select at least one of these: Race: ☐ AmerIndian/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

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: 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**		
Allergies *(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 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:* ____/____/____