

# CONFIDENTIAL STUDENT INFORMATION CARD

Complete and return this form to school promptly. Please write legibly.

School Name \_\_\_\_\_ Elementary Middle High Other (circle one)

Teacher \_\_\_\_\_ Grade Level of Student \_\_\_\_\_

Student ID # \_\_\_\_\_ How student gets to/from school (check one):  Bus  Walker  Parent Drives

Special Needs Bus  Student Drives  Other \_\_\_\_\_

## YOUR CHILD

Student's Name \_\_\_\_\_  
Last First MI Jr., II, etc.

Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Country of Birth \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address (if other than street address) \_\_\_\_\_ Zip Code \_\_\_\_\_

What kind of dwelling do you live in?  Single-family detached home or mobile home  Townhouse or duplex  Apartment or condo

Do preschool siblings (ages 4 and younger) live at this address?  Yes  No How many? \_\_\_\_\_ Ages? \_\_\_\_\_

## PARENTS/GUARDIANS

1. Mr/Ms/Mrs \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_

Phone\* (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email\* \_\_\_\_\_ Employer (company name) \_\_\_\_\_

2. Mr/Ms/Mrs \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_

Phone\* (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email\* \_\_\_\_\_ Employer (company name) \_\_\_\_\_

Primary language spoken at home \_\_\_\_\_ Do you need an interpreter to communicate with the teacher or school?  Yes  No

\*Phone numbers and email address may be used for emergency notification.

## TEMPORARY CARE

List two nearby adults who will assume temporary care of your child if you cannot be reached. PLEASE IDENTIFY CHILDCARE PROVIDER.

1. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

## BUS TRANSPORTATION

Bus Number (AM) \_\_\_\_\_ Bus Number (PM) \_\_\_\_\_

If your child rides a bus and will be regularly picked up or dropped off at an alternate bus stop, please indicate:

Name of Responsible Adult \_\_\_\_\_ Phone \_\_\_\_\_

Alternate Pick-Up Street Address \_\_\_\_\_ Zip \_\_\_\_\_

Bus Number – Alternate (AM) \_\_\_\_\_ Days for Alternate Pick Up (please circle) M T W Th F

Name of Responsible Adult \_\_\_\_\_ Phone \_\_\_\_\_

Alternate Drop-Off Street Address \_\_\_\_\_ Zip \_\_\_\_\_

Bus Number – Alternate (PM) \_\_\_\_\_ Days for Alternate Drop Off (please circle) M T W Th F

## MILITARY ACCESS TO STUDENT INFORMATION

Federal law entitles military recruiters to access secondary students' names, addresses and phone numbers unless parents or students annually request such information not be released.  Do not release student's contact information. Signature \_\_\_\_\_

## YOUR CHILD AND MEDIA EXPOSURE

In the course of school activities, FCPS staff and/or the news media occasionally wish to interview, photograph or videotape students, and/or make public their names, work or likenesses in print, on television, radio or by electronic means such as the Internet. This includes but is not limited to honor roll, school publications and artwork. Unless indicated otherwise below, we will assume your permission to do so. (FCPS cannot control media coverage of events that are open to the public.)

I give permission Signature \_\_\_\_\_

I deny permission Signature \_\_\_\_\_

# CONFIDENTIAL HEALTH AND EMERGENCY INFORMATION

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

## HEALTH CARE CONTACTS

Health Care Provider/Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance [  ] Yes Health Insurance Company: \_\_\_\_\_ [  ] No

## STUDENT'S MEDICAL HISTORY (Please check or complete information that applies):

Contact school nurse to set up a care plan for your child.

Allergies:	Briefly Describe Reaction:
____ Medications (Specify) _____	_____
____ Foods (Specify) _____	_____
____ Latex _____	_____
____ Bees _____	_____
____ Pesticide/Chemicals* _____	_____
____ Other (Specify) _____	_____

## Chronic Health Condition(s) and Comments:

\_\_\_\_ Asthma \_\_\_\_\_  
\_\_\_\_ Seizure Disorder \_\_\_\_\_  
\_\_\_\_ Diabetes \_\_\_\_\_  
\_\_\_\_ Other (Specify) \_\_\_\_\_

## Additional History and Comments:

\_\_\_\_ Hearing Problems (Specify) \_\_\_\_\_  
\_\_\_\_ Vision Problems (Specify) \_\_\_\_\_  
\_\_\_\_ Physical Disabilities (Specify) \_\_\_\_\_  
\_\_\_\_ Other (Specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Medications: (please list)

## Medical Condition Treated:

_____	_____
_____	_____
_____	_____
_____	_____

If the student requires over-the-counter or prescription medications or treatments at school, the health care provider/physician and parent **must** complete and submit the appropriate authorization form(s). Obtain forms from the health staff at your child's school or at <http://www.fcps.org/> (then click on "Forms").

\* FCPS uses the Integrated Pest Management program to identify and control pest problems in schools. **Elementary** schools must notify staff and parents/guardians of all students 24 hours before pesticides are to be applied inside the school building or on the grounds. **Middle and high schools** must notify only those parents, guardians or staff who have filed a written request for notification; forms are available at each school and must be updated every school year. (See the FCPS Calendar Handbook for details, or contact your school.)

**IMPORTANT:** The information I have provided regarding my child's health may be shared with FCPS/Frederick County Health Department staff as appropriate. In case of accident or serious illness, I request that school staff contact me. If I cannot be reached, I hereby authorize school staff to call the physician indicated ABOVE or make reasonable arrangements deemed to be in the best interest of the child.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_