# The Villages Charter School

**2018-2019 EMERGENCY CONTACT/STUDENT INFORMATION SHEET**

___PC
___IC
___4-5
___MS
___HS

**Student's Legal Name**_____D.O.B._____M/F _____

School _____ Grade _____ Teacher _____

Student's SS#_____ Student Lives with _____

**FAMILY 1: Primary Legal Guardian (student's primary residence)**

Guardian 1: _____ Relationship: _____ ☐ Custody ☐ Qualifying Parent

Home Phone: _____ Cell Phone: _____ Email Address:_____

Work Phone: _____ Place of Employment _____

Guardian 2: _____Relationship: _____ ☐ Custody ☐ Qualifying Parent

Home Phone: _____ Cell Phone: _____ Email Address:_____

Work Phone: _____ Place of Employment _____

Resident Address: _____City: _____ State: _____ Zip: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Siblings/Students associated with Family 1 (Name, School, and Grade):

_____

**FAMILY 2: Secondary Legal Guardian (student's secondary residence)**

Guardian 1: _____ Relationship: _____ ☐ Custody ☐ Qualifying Parent

Home Phone: _____ Cell Phone: _____ Email Address:_____

Work Phone: _____ Place of Employment _____

Guardian 2: _____Relationship: _____ ☐ Custody ☐ Qualifying Parent

Home Phone: _____ Cell Phone: _____ Email Address:_____

Work Phone: _____ Place of Employment _____

Resident Address: _____City: _____ State: _____ Zip: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Siblings/Students associated with Family 2 (Name, School, and Grade):

_____

**PERSON(S) AUTHORIZED TO PICK UP AND WHO WILL CARE FOR CHILD IN CASE PARENT/GUARDIAN CANNOT BE REACHED**

NAME_____ Phone# _____ Relationship _____

NAME_____ Phone# _____ Relationship _____

NAME_____ Phone# _____ Relationship _____

NAME_____ Phone# _____ Relationship _____

PERSON(S) WHO **MAY NOT** PICK UP STUDENT **BY COURT ORDER ONLY** (MUST PROVIDE LEGAL DOCUMENTATION)

Name/Relationship _____Name/Relationship_____

**Health Information** **Glasses, Contacts, or Hearing Aids**: _____

***If any of the following health conditions are marked yes, documentation of conditions must be provided from your child's physician***

Does your child have any of the following conditions: **Asthma** Yes___ No___ **Seizures** Yes___ No___ **Diabetes** Yes___ No___

Allergy to**: Medication** Yes___ No___ If **Yes** list: _____ **Food** Yes___ No___ If **Yes** list: _____

**Insects** Yes___ No___ If **Yes** list: _____ **Allergies** Yes___ No ___ If **Yes** please list: _____

**Muscular/Skeletal Problem** Yes___ No___ If Yes list condition: _____

**Heart Disease** Yes___ No___ **ADD/ADHD** Yes___ No___ **Hemophilia/Bleeding Disorder** Yes___ No___ **Other**_____

Do you wish a doctor to be listed for emergency contact? Yes___ NO___ If yes please provide the doctor name and number below.

**The information comprised on this form is correct to the best of my knowledge. I will not hold the school responsible for any incorrect information given. If any changes occur in this information, I understand it is my responsibility to contact the school immediately.**

**Signature of Parent/Guardian** _____ **Date**_____

***Please Note: It is the parents' responsibility to immediately notify the school of any changes to the information provided on this sheet.***

*The Villages Charter School Non-Discrimination Statement: No person shall, on the basis of race, color, religion, sex, age, national ethnic origin, marital status, qualified handicap or disability or social and family background, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity under the direction of The Villages Charter School.*