

The Villages® Charter School

2017-2018 EMERGENCY CONTACT/STUDENT INFORMATION SHEET

___ PC
___ IC
___ 4-5
___ MS
___ HS

School _____ Grade _____ Teacher _____

Student's Legal Name _____ D.O.B. _____ M/F _____

Student Lives with _____

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

Guardian 1: _____ Relationship: _____ Pick Up Custody

Primary Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ **Qualifying Parent? Yes / No**

Guardian 2: _____ Relationship: _____ Pick Up Custody

Cell Phone: _____ Work Phone: _____

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: _____ Pick Up Custody

Primary Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ **Qualifying Parent? Yes / No**

Guardian 2: _____ Relationship: _____ Pick Up Custody

Cell Phone: _____ Work Phone: _____

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# _____ Name _____ Phone # _____

NAME _____ Phone# _____ Name _____ Phone # _____

PERSON(S) WHO MAY NOT PICK UP STUDENT (MUST PROVIDE LEGAL DOCUMENTATION)

Name/Relationship _____ Name/Relationship _____

Health Information

Glasses, Contacts, or Hearing Aids: _____

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.

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

Signature of Parent/Guardian _____ Date _____

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 form.

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.