

2017-2018

# Student Information Form

1. Verify/correct information on this form AND return to the school secretary.
2. \*\* Please be sure to add/verify your current email address to facilitate communication!
3. Be sure to sign at the bottom of page 2 and return this form to the school secretary

<p>Salem High School</p> <p>Homeroom: _____</p>
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Student Full Name: _____	Is student in foster care (Y/N)? _____
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Preferred Name: _____ Physical/Street Address: _____ City, State, Zip _____ Student is a legal resident of: _____ Student Lives With: _____	Student Number: _____ Grade Level: _____ Gender: _____ Date Of Birth: _____ * Student's Cell: _____ * Student's Email: _____
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<b>New Federal Race and Ethnicity Reporting - Required</b> Is English the Primary language spoken in the home (Y/N)? _____ If NO, what is the primary language/dialect? _____ * Ethnicity: Is student Hispanic? Yes OR No: _____	Check one: _____ Asian _____ Black or African American _____ American Indian or Alaskan _____ Native Hawaiian/ Other Pacific Isl _____ White
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<b>First Parent/Guardian to be contacted by the school:</b> Name: _____ * Email Address: _____ Legal Custody of Child? _____ Relationship to Student: _____ Street Address: _____ City, State Zip _____	<b>Prioritize your phone numbers in the order you want to be contacted.</b> <i>Include Area Code! - (eg. 540-555-1212)</i> <span style="float: right;"><u>Is Work Phone?</u></span> Primary Phone: _____ <input type="checkbox"/> Second Phone: _____ <input type="checkbox"/> Third Phone: _____ <input type="checkbox"/> Employer Name: _____ Position/Dept. _____
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<b>Second Parent/Guardian to be contacted by the school:</b> Name: _____ * Email Address: _____ Legal Custody of Child? _____ Relationship to Student: _____ Street Address: _____ City, State Zip: _____	<b>Prioritize your phone numbers in the order you want to be contacted.</b> Primary phone: _____ <input type="checkbox"/> Second phone: _____ <input type="checkbox"/> Third phone: _____ <input type="checkbox"/> Employer Name: _____ Position/Dept. _____
** If the second contact lives at a different address, do they require a copy of all mailings? Y/N: _____	

First Emergency Contact (Relative or Neighbor) to be called if Parental contacts cannot be reached (Required)

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Primary phone #: \_\_\_\_\_

Second phone #: \_\_\_\_\_

Third phone #: \_\_\_\_\_

Second Emergency Contact (Relative or Neighbor) to be called if Parental contacts cannot be reached (Required)

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Primary Phone # \_\_\_\_\_

Second Phone # \_\_\_\_\_

Third Phone # \_\_\_\_\_

Transportation

SCS\_Bus\_AM: \_\_\_\_\_

SCS\_Bus\_PM: \_\_\_\_\_

Enter Bus Number or Day Care Name or "Walks" or "Drives" or "Parent Drives" as applicable for morning and afternoon.

**Permissions - Directory Information/Photo:**

During the school year, Salem City Schools has my permission to use and to distribute the name, picture, voice, visual image, or opinions of the student in any school-related productions, promotions, videos, newspaper articles, web pages, etc.

Yes/No: \_\_\_\_\_

Electronic Affirmation Initials: \_\_\_\_\_

**Permissions - Medical Treatment:**

If a parent/legal guardian cannot be reached in the case of emergency, illness, or injury, the school is authorized to follow whatever procedure is necessary to secure medical treatment as needed?

Yes/No: \_\_\_\_\_

Electronic Affirmation Initials: \_\_\_\_\_

Student's Primary Doctor: \_\_\_\_\_

Doctor's Facility or Address: \_\_\_\_\_

Doctor's Office Phone: \_\_\_\_\_

List EMERGENCY MEDICAL ALERTS for this student. (check - or list below including Special Diet, other SIGNIFICANT physical or emotional conditions)

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ADD/ADHD: \_\_\_ Cancer: \_\_\_ Epilepsy/Seizures: \_\_\_ Food Allergy - Epipen: \_\_\_

Asthma: \_\_\_ Heart: \_\_\_ Gastro Intestinal: \_\_\_ Insect Allergy - Epipen: \_\_\_

Autism: \_\_\_ Diabetes: \_\_\_ Hearing Impaired: \_\_\_ Latex Allergy - Epipen: \_\_\_

Bleeding: \_\_\_ Kidney: \_\_\_ Migraines: \_\_\_

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List NON-EMERGENCY Medical Comments you wish the school to be aware of for this student.

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Prescription Medications

Is prescription medication on a regular basis? Yes/No: \_\_\_\_\_

Is any medicine taken during school hours? Yes/No: \_\_\_\_\_

(Note: Specific names of medicines will be obtained separately from Parents)

X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Parent/Legal Guardian Date

Signature affirms the Permissions statements (Directory/Photo Medical Treatment) to the left.  
 (Note: This form may have been printed before some online submissions were received)