III. Siblings

19. Complete this section only if applicable. Include only siblings who are currently in Grades PK-8 in this school.

Sibling #1 full name:	Grade:	School Name:
Sibling #2 full name:	Grade:	School Name:
Sibling #3 full name:	Grade:	School Name:
Sibling #4 full name:	Grade:	School Name:

IV. Previous Schools

20. Last Elementary School Attended			Grade
21. Address	City	State	Zip

V. QUESTIONS FOR PARENTS

22. Has student ever received service from or been involved in: (check all that apply):

☐ Special Education ☐ Title I ☐ Reading Tutor ☐ Speech Therapy ☐ Gifted Program
☐ English 2nd Language ☐ Behavior Management ☐ Counseling ☐ Other:

23. Has this student ever been under long term suspension or been suspended from school? ☐ Yes ☐ No

24. Legal Bindings: Please list any legal binding information, including restraining orders, custody agreements that are pertinent to this student and his/her safety: (copy of the legal documentation is required).

25. Is there any other information that would help us better serve your student?

26. Continuing Consent to Treatment and Authorization to Release Information

I, the undersigned parent/guardian of the above named student, do hereby consent to any x-ray, examination, anesthetics, medical or surgical diagnosis or treatment, and hospital service that may be rendered to said minor under the general or special instruction of the above named physician or a licensed hospital. It is understood that reasonable effort will be made to contact the physician listed above before any other physician is called.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize the school or the physician to exercise their best judgment as to the requirement of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or the school.

I hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the student accident insurance carrier or its representative any and all information with respect to any illness, medical history, consultation, x-ray, or treatment, and copies of all hospital or medical records. A copy of this authorization shall be considered as effective and valid as the original.

Signed:_____ Date: _____

Witness:_____ Date: _____

27. Directory of Students

I give permission to publish parent & student names, addresses, phone number, and student's grade level in school directory.

☐ Yes ☐ No

28. Photographic Release

I give permission to use photos for publicity, promotional, and school/conference use.

☐ Yes ☐ No

OFFICE ONLY Student Name: _____ Grade: _____ Teacher: _____ Student ID: _____

Submit