Student Contact Information

(for class use only)

Student's Name:_____Teacher's Name:_____

Student's Mailing Address:_____

Student's Birthday:_____

Sibling(s) at S.C.: _____

Mother's (or guardian's) Name: _____

Mother's Phone – Home:_____Work:_____ Cell:_____

Mother's Workplace:_____ Mother's e-mail:_____

Father's (or guardian's) Name:_____

Father's Phone – Home:_____Work:_____ Cell:_____

Father's Workplace:_____Father's e-mail:_____

Emergency Contact Information (in the event you cannot be reached):

Name Address Phone Number

1._____

2._____

Please see reverse side for more information.

Student Contact Information

(for class use only)

Student's Name:_____Teacher's Name:_____

Student's Mailing Address:_____

Student's Birthday:_____

Sibling(s) at P.K.: _____

Mother's (or guardian's) Name: _____

Mother's Phone – Home:_____Work:_____ Cell:_____

Mother's Workplace:_____ Mother's e-mail:_____

Father's (or guardian's) Name:_____

Father's Phone – Home:_____Work:_____ Cell:_____

Father's Workplace:_____Father's e-mail:_____

Emergency Contact Information (in the event you cannot be reached):

Name Address Phone Number

1._____

2._____

Please see reverse side for more information.

Other Individuals Authorized to pick up your child from school: (if different from emerg. contact)

Name Address Phone Number

1._____

2._____

3._____

Is or will your child be registered in the Bluewave Afterschool Program? ❍ yes ❍ no

Important Medical Information:

Does your child have any food allergies, insect sting reactions, special medications, etc.?

_____

_____

Child's Doctor: _____ Doctor's Phone No:_____

Parent Signature:_____Date:_____

Please complete this form and return it to your child's teacher—thank you!

Other Individuals Authorized to pick up your child from school: (if different from emerg. contact)

Name Address Phone Number

1._____

2._____

3._____

Is or will your child be registered in the Bluewave Afterschool Program? ❍ yes ❍ no

Important Medical Information:

Does your child have any food allergies, insect sting reactions, special medications, etc.?

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Child's Doctor: _____ Doctor's Phone No:_____

Parent Signature:_____Date:_____

Please complete this form and return it to your child's teacher—thank you!