# LeRoy Junior/Senior High School
# 2016/2017 Student Registration Information Form

***Student:*** _____ Social Security No._____ Date: _____
(Please provide full name - first, middle and last)

Gender: _____ Birthdate: _____ 2016/2017 Grade: _____ Bus Rider: ☐ Yes ☐ No

Home Phone #: _____ Home Address:_____ County of Residence:_____

Birth City: _____ Birth State: _____ Birth County: _____

Student Cell Phone Number (emergency use): _____

Mother/Guardian: _____ Father/Guardian: _____

Mother Address: _____ Father Address: _____

Mother/Guardian Work Place: _____ Father/Guardian Work Place: _____

Mother/Guardian Work Phone: _____ Father/Guardian Work Phone: _____

Mother/Guardian Cell Phone: _____ Father/Guardian Cell Phone: _____

e-mail address: _____ e-mail address: _____

1st Emergency Contact: _____ 1st Emergency Phone #: _____
(Person other than parent/guardian) (Number other than home phone)

2nd Emergency Contact: _____ 2nd Emergency Phone #: _____
(Person other than parent/guardian) (Number other than home phone)

Health Notes: _____
I agree that this information may need to be shared with other school personnel for proper handling of procedures related to these conditions.

Sibling(s)/Grade/age (if not in school) _____

Ethnic Background: ☐ White ☐ Black ☐ Hispanic Sibling(s)/Grade/age (if not in school) _____

☐ Asian/Pacific Islander ☐ Native American Sibling(s)/Grade/age (if not in school) _____

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***TRANSPORTATION:*** If transportation is needed for our child in case of illness or injury, we agree that he/she be transported in a privately owned car or commercial vehicle.

***MEDICAL TREATMENT:*** I hereby give the administration of LeRoy C.U.S.D. #2 authorization on my behalf to consent for emergency medical treatment of my son/daughter _____ in my absence. This authorization is valid while my child is attending school or a school sponsored activity.

***PHYSICIAN:*** If, in the judgment of the school authorities, a physician is needed and we (the parent/guardian) cannot be contacted, the school is directed to call:

Doctor: _____ Doctor Phone/Address _____

***HOSPITAL CALL:*** In case hospitalization is needed, you may transport the ill or injured child to the following hospital if it is possible for him/her to be cared for there. We grant permission for transportation by ambulance, privately owned car, or commercial vehicle.

Hospital: _____ Hospital Phone: _____

Dentist of Choice: _____ Dentist Phone: _____

***Parent Signature (Required):*** _____ ***Date:*** _____