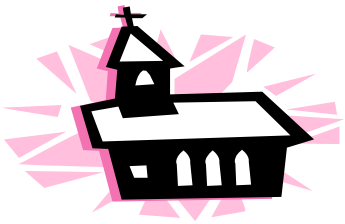

Office Use Only:

Year: 16/17
Grade: _____
Room: _____

ELEMENTARY PSR INFORMATION SHEET

STUDENT'S NAME: _____
First Last

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

ADDRESS: _____
Number & Road City Zip

PHONE: HOME _____ PARENT'S CELL _____

PARENT'S E-MAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

MOTHER'S NAME: _____
First Last Mother's Maiden Name

FATHER'S NAME: _____
First Last

CHARACTER OF HOME: (Please Circle)

A. Two Parent Family
B. Single Parent and child is living with… a. Father b. Stepfather c. Mother d. Stepmother
C. Court Ward/Foster Child
D. Father is deceased
E. Mother is deceased

Guardian (If applicable) _____ Religion _____
Address _____ Phone _____

Are Parents Divorced? _____Yes _____ No
If parents are divorced, are there any custody restrictions we need to be aware of?
Please note:
_____
_____

PUBLIC SCHOOL CHILD IS CURRENTLY ATTENDING: _____

May we take pictures/video of your child for PSR purposes? _____ Yes _____No

LEARNING DISABILITIES/SPECIAL NEEDS:
In order to provide the best Christian learning environment possible for your child, please list below any special learning disabilities or physical handicaps that your child may have. This information will be available only to the administration and the teacher. If you would like to discuss this in more detail, please call Mrs. Lori Mascia at 440-449-4242 Ext. 119.

_____
_____

Parent/legal Guardian Signature _____

PART I OR II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at: (___)_____or_____
(phone) (other parent)
at ( ) _____ have been unsuccessful, I hereby give my consent for: (1) The administration of any treatment deemed necessary by Dr. _____, or Dr. _____ or in the
(dentist) (physician)
event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) The transfer of the child to: _____ hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained before surgery is performed.

Date: _____ Signature of Parent or Guardian: _____

PART II (REFUSAL TO CONSENT)
DO NOT COMPLETE PART II IF YOU COMPLETED PART I

I **do not** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

_____

_____

Date: _____ Signature of Parent or Guardian: _____

It is also necessary for us to have the doctor's name and phone number.
Please include this information below:

Doctor: Name: _____ Phone: _____

Dentist: Name: _____ Phone: _____

RE: Privacy Act. It is understood that no student information will be given out without parental consent. However, we wish to inform you that your name and home phone number will be given to selected adults who will keep the information confidential and will use it only to inform you of emergency situations. If you have any problem with this policy, please call me at (440) 449-4242 ext. 119.

I have read the above statement regarding the Privacy of Student Information.

Date: _____ Signature: _____