

Grade: _____

Class: _____

North Valley Academy 2010-2011 Student Contact Information

Updated: _____

Initials: _____

Student's Name: _____ Date of Birth: _____ Sex: Male Female

Street Address: _____

City, State & Zip Code: _____

(Guardian 1):

Name: _____

Home Address: _____

Hm. Ph: _____ Cell Ph: _____

Business Name: _____

Wk Ph: _____

Relationship to Student: _____

(Guardian 2):

Name: _____

Home Address: _____

Hm. Ph: _____ Cell Ph: _____

Business Name: _____

Wk Ph: _____

Relationship to Student: _____

If Medical Care is Necessary, Call:

DOCTOR: _____

Name

Address

Phone

HOSPITAL: _____

Name

Address

Phone

In case of injury or sudden illness, _____ will be called first. I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

In case of an emergency, or if I cannot be contacted to pick up my child, I hereby authorize the following person(s) to pick up my child.

Name: _____

Relationship: _____

Ph: _____ Cell Ph: _____

Name: _____

Relationship: _____

Ph: _____ Cell Ph: _____

Name: _____

Relationship: _____

Ph: _____ Cell Ph: _____

Name: _____

Relationship: _____

Ph: _____ Cell Ph: _____

Name: _____

Relationship: _____

Ph: _____ Cell Ph: _____

Name: _____


Relationship: _____

Ph: _____ Cell Ph: _____

The following person(s) may not remove my child from the facility:

Name: _____ Name: _____

Custody papers have been provided and are on file at the facility. Yes No

Continued on back 

PRESS & PUBLICITY RELEASE

I authorize North Valley Academy to use the photograph, likeness, and/or replication of my child in usual and customary press, publicity, and school publication purposes.

(Check those you wish to authorize for use)

Class Web Page

NM Pre K Web Site and Related

NVA Yearbook

Class Non Web Publications (i.e. newsletters)

School Web Site

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY TO WHICH A PHYSICIAN SHOULD BE ALERTED

Please indicate if the student has had or is currently under treatment for any of the following conditions:

Condition	Year/Age Problem Occurred	Condition	Year/Age Problem Occurred
Asthma		Infections Diseases	Type:
Diabetes		Migraine Headaches	
Ear/Hearing Problems	Type:	Heart Problems	Type:
Emotional Problems	Type:	Bleeding Disorders	Type:
Seizures		High Blood Pressure	
Hepatitis		Muscular Weakness or Paralysis	
Meningitis			
Other:			

Allergies:

Reactions to Medicine or Injections?

Hospitalized for Serious Illness, Surgery or Accidents? (If yes, explain) Yes No

Use of Contact Lenses? Yes No

--

Long Term Medications (List Below)

Name of Medication	Dosage	Name of Medication	Dosage

This **Contact Information Form** is accurate and complete, front and back, and was provided by:

Parent or Guardian printed name: _____

Signature: _____ **Date:** _____