STUDENT INFORMATION

ARLINGTON PUBLIC SCHOOLS

This form must be completed by the parent/legal guardian and must be returned on the ***second day of school.*** **PRESS HARD/PRINT**

This information can now be filled out online using APS ParentVue. If you prefer to complete the online form, please visit: www.apsva.us/familyaccess

STUDENT NAME (LAST, FIRST, MIDDLE) as it appears on birth certificate	GENDER	BIRTH DATE (MM/DD/YY)	GRADE	ROOM #

ADDRESS WHERE STUDENT LIVES	ZIP CODE	HOME TELEPHONE ( )

WITH WHOM DOES THE STUDENT LIVE?	Preferred Language for messages/mailings

PARENT OR LEGAL GUARDIAN (LAST, FIRST, MIDDLE)	E-MAIL ADDRESS

ADDRESS (IF DIFFERENT FROM STUDENT'S)	WORK TELEPHONE ( )	CELL PHONE ( )

PARENT OR LEGAL GUARDIAN (LAST, FIRST, MIDDLE)	E-MAIL ADDRESS

ADDRESS (IF DIFFERENT FROM STUDENT'S)	WORK TELEPHONE ( )	CELL PHONE ( )

PERSON(S) TO BE CALLED WHEN PARENT(S) CANNOT BE REACHED AND TO WHOM THE SCHOOL MAY RELEASE YOUR CHILD DURING AN EMERGENCY SITUATION

Health information about your child will be shared with this person ONLY as it relates to the specific reason he/she is being called.

(LAST NAME, FIRST NAME, MIDDLE INITIAL)	RELATIONSHIP TO STUDENT	DAYTIME TELEPHONE NUMBER ( )
1)		
(LAST NAME, FIRST NAME, MIDDLE INITIAL) 2)	RELATIONSHIP TO STUDENT	DAYTIME TELEPHONE NUMBER ( )
(LAST NAME, FIRST NAME, MIDDLE INITIAL) 3)	RELATIONSHIP TO STUDENT	DAYTIME TELEPHONE NUMBER ( )

PHYSICIAN/INSURANCE INFORMATION:

NAME OF STUDENT'S REGULAR DOCTOR	TELEPHONE NUMBER ( )

Does your child have health insurance? ❑ Yes ❑ No	INSURANCE PROVIDER NAME	INSURANCE IDENTIFICATION NUMBER

MEDICAL INFORMATION

Check the appropriate box to indicate any current health condition that may require attention during the school day. Please notify the school nurse if your child has a severe or life-threatening allergic reaction to any foods or other allergens. The school nurse will work with you to develop a care plan for your child. *(A copy of the Care Plan is available from the School Clinic or the School Health website)*

❑ Life-Threatening Allergies (list all that apply)
- ❑ Foods _____
- ❑ Medicines _____
- ❑ Other _____

❑ Diabetes
❑ Hearing Problems ❑ Hearing aid(s)
❑ Heart Problems
❑ Hemophilia
❑ Physical Disability (be specific) _____
❑ Asthma or other breathing problems
❑ Seizures
❑ Cancer — Concurrently under treatment? ❑ Yes ❑ No
❑ Vision Problems ❑ Glasses ❑ Contacts
❑ Other (Be specific, use other side if necessary)

MEDICATIONS (ex. Epipen, glucagon, inhaler, Diastat, insulin, etc.)

Has your child been prescribed any emergency medications? Please list _____

What medications does your child take at school? _____

What medications does your child take at home? _____

If your child is unable to leave school at the normal time due to an emergency, are there medications that your child must take? Please list medication and indicate reason. _____

A SEPARATE MEDICATION AUTHORIZATION FORM MUST BE COMPLETED FOR ANY MEDICATION(S) TO BE GIVEN AT SCHOOL. These forms may be obtained from the school clinic staff, or on the School Health website: (*www.apsva.us/schoolhealth*)

Parent/Guardian Signature: X _____ Date: _____

Distribution: **White:** Nurse; **Yellow:** Office; **Pink:** Elem. - Home Room Teacher; Middle - TA; High - 3rd Period Teacher **updated 7/13, SCR**

IMPORTANT: PLEASE NOTIFY SCHOOL STAFF OF ANY CHANGES TO THE ABOVE INFORMATION