

SPECIAL SCHOOL DISTRICT OF ST. LOUIS COUNTY  
STUDENT ENROLLMENT/EMERGENCY CONTACT FORM

School Year \_\_\_\_\_

**STUDENT DATA:**

Name: \_\_\_\_\_ Student ID \_\_\_\_\_  
Last First MI  
Date of Birth: \_\_\_\_\_ Gender: Male / Female Race: \_\_\_\_\_  
Student Address: \_\_\_\_\_  
Street Number City/State Zip  
Home District: \_\_\_\_\_ Attending School: \_\_\_\_\_

**PARENT/LEGAL GUARDIAN #1 – First contact**

Name: \_\_\_\_\_  
Spouse/Partner: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Email: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**PARENT/LEGAL GUARDIAN #2 – Second contact**

Name: \_\_\_\_\_  
Spouse/Partner: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Email: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**FOR EMERGENCY USE WHEN PARENT CANNOT BE LOCATED:** Persons listed below has your authorization to pick up your child.

**FIRST EMERGENCY CONTACT**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phones: Home \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**SECOND EMERGENCY CONTACT**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phones: Home \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

1. Are you sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason?  
 Y  N Explain if it is a similar reason: \_\_\_\_\_
2. Are you currently residing at a motel, hotel, in a car, or at a campsite because your home has been damaged or because of economic reasons?  Y  N
3. Are you currently residing in a shelter?  Y  N
4. Are you currently living in a temporary housing arrangement due to economic hardship?  Y  N
5. Has a family member moved w/children in the last 3 years to seek temporary or seasonal agricultural or processing work?  Y  N
6. Is the parent/guardian currently active Military?  Y  N

**HEALTH CARE PROVIDERS**

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Hospital: \_\_\_\_\_  
 Insurance Plan: \_\_\_\_\_ Membership Number: \_\_\_\_\_  
 Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

**Health Information:** To be completed by parent or guardian prior to entry into Special School District.

Does student have a history of:  Asthma  Diabetes  Heart Condition  Convulsive Disorder

Allergies List: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

Other Medical Concerns: \_\_\_\_\_

Medications: List all medications, give name(s) amounts and time medication is taken: \_\_\_\_\_

Does the student have Down Syndrome? \_\_\_\_\_ If yes, has a physician examined and x-rayed, including full flexion and full extension views, for Atlantoxial Subluxation? Yes \_\_\_\_\_ Date of x-ray \_\_\_\_\_

No x-ray taken \_\_\_\_\_ (Signed release from doctor must be provided)

Hearing Loss?  Y  N Hearing Aid(s)  Y  N Contact Lenses?  Y  N Glasses?  Y  N

Date of Last physical exam: \_\_\_\_\_ Date of Tetanus Booster: \_\_\_\_\_

**EMERGENCY PROCEDURE:** In case of injury or illness requiring medical care, you have my permission to obtain such care from the nearest hospital and to release personally identifiable information regarding my child. I agree to pay all expenses incurred in such emergency care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_