

STUDENT INFORMATION

Last Name:		First Name:	Middle Name:
Other Name(s) used (AKA):		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Birth City:		State:	Country:
Residence Address:		City:	Zip Code:
Mailing Address:		City:	Zip Code:

PARENT/GUARDIAN INFORMATION

1. Parent/Guardian Last Name:		First Name:	Cell Phone:	Work Phone:
Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step Father <input type="checkbox"/> Step Mother <input type="checkbox"/> Caregiver		E Mail Address:		Parent Primary Language:
Check as Needed: <input type="checkbox"/> No Mail <input type="checkbox"/> Copy of all Mail <input type="checkbox"/> Copy of Grades Only				
2. Parent/Guardian Last Name:		First Name:	Cell Phone:	Work Phone:
Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step Father <input type="checkbox"/> Step Mother <input type="checkbox"/> Caregiver		E Mail Address:		Parent Primary Language:
Check as Needed: <input type="checkbox"/> No Mail <input type="checkbox"/> Copy of all Mail <input type="checkbox"/> Copy of Grades Only				
Parent Education Level - indicate highest level completed: <input type="checkbox"/> Not a High School Graduate <input type="checkbox"/> Graduate Degree or Higher <input type="checkbox"/> High School Graduate <input type="checkbox"/> Some College or Associate's Degree <input type="checkbox"/> College Graduate				
Is either Parent/Guardian on active Military Duty? Circle: Yes or No				
If yes, circle which branch: Army Navy Air Force Marine Corps Coast Guard				
Is there a biological parent <u>not</u> living at home? <input type="checkbox"/> Yes (Complete below) <input type="checkbox"/> No				
Parent /Guardian Last Name:		First Name:	Cell Phone:	Work Phone:
Residence Address:		City:	Zip Code:	
Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother				
Is there a legal custody agreement regarding this student <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide school with a copy of the most recent custody orders				

ADDITIONAL STUDENT INFORMATION

Has your child attended Oakdale Joint Unified School District? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, Name of School: _____ Year(s) : _____	
Last School Attended: _____ Address: _____	
State: _____ Zip: _____ Grade: _____ Last Day of Enrollment: _____	
California School Entry Date: _____ U.S. School Entry Date: _____	
Has your child been retained: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what grade? _____	
Has your child ever been expelled: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, name of school and district: _____	
Is your child currently under SARB directives: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ethnicity: (Select One): <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino	
Race: (Please select one or more, regardless of Ethnicity):	
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hmong <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Cambodian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Japanese <input type="checkbox"/> Laotian <input type="checkbox"/> Tahitian <input type="checkbox"/> Korean <input type="checkbox"/> Filipino <input type="checkbox"/> Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> White <input type="checkbox"/> Black or African American	
Residence Status – Where is your child/family living: (check one)	
<input type="checkbox"/> Permanent Residence <input type="checkbox"/> Unsheltered <input type="checkbox"/> Group Home* <input type="checkbox"/> Temporary Shelter <input type="checkbox"/> Motel/Hotel <input type="checkbox"/> Unaccompanied Minor <input type="checkbox"/> Runaway <input type="checkbox"/> Foster Home* <input type="checkbox"/> Temporarily w/ another family	
*Social Worker Name: _____ Phone #: _____	
*Student's Attornev: _____ Phone #: _____	

*Foster Placement Agency: _____ Phone #: _____

Student Name: _____ **DOB:** _____ **Grade:** _____ **School:** _____

Student Services: (Check all that apply)

<input type="checkbox"/> Resource (RSP)	<input type="checkbox"/> Special Day Class (SDC)	<input type="checkbox"/> Speech/Language (SLP)
<input type="checkbox"/> ELD	<input type="checkbox"/> Counseling	<input type="checkbox"/> Remedial Reading
<input type="checkbox"/> IEP	<input type="checkbox"/> GATE	<input type="checkbox"/> Remedial Math
<input type="checkbox"/> 504	<input type="checkbox"/> Migrant	<input type="checkbox"/> Other: _____

SIBLING INFORMATION

Complete this section only if applicable. Include all siblings.

Full Name:	Date of Birth:	Grade:	School:
Full Name:	Date of Birth:	Grade:	School:
Full Name:	Date of Birth:	Grade:	School:
Full Name:	Date of Birth:	Grade:	School:

PLEASE READ: The parent/guardian is responsible for keeping updates/changes to the student's emergency information. The school shall be notified in writing, of phone or address changes within 3 days of the occurrence. If the school is unable to reach anyone on this card in an emergency or if a student is left at school during non-school hours, the school will contact law enforcement or Child Protective Services.

EMERGENCY CONTACT INFORMATION

Note: The adults listed below are authorized to pick up and care for the above named student.

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

GENERAL HEALTH INFORMATION

Health Problems: (check all that apply) If none please check here:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Asthma	<input type="checkbox"/> Major Surgery	_____
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Emotional Concerns	_____
<input type="checkbox"/> Seizure Disorder	Type _____	<input type="checkbox"/> Known Hearing Loss	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Heart Problem		<input type="checkbox"/> Wear Glasses	<input type="checkbox"/> Contacts
Restrictions _____		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Chronic Health Condition	_____		

Allergies-Specific items(s) student has been diagnosed as allergic to:

<input type="checkbox"/> Bee Sting:	Doctor diagnosis requires Epi Pen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Food (type): _____	Doctor diagnosis requires Epi Pen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Other (type): _____	Doctor diagnosis requires Epi Pen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please give details of any items checked:

1. _____

2. _____

In the event of an emergency, when a parent/guardian is unavailable, I authorize school personnel to make such arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgement. I further authorize the physician named below to undertake such care, as he/she considers necessary. In the event the said physician is not available, I authorize such care and treatment to be performed by a licensed physician or surgeon. I understand that the parent/guardian is responsible for the cost of such emergency care.

Physician Name: _____ Phone: _____

I have viewed this document and to the best of my knowledge, the information contained herein is true and complete. The undersigned declares penalty of perjury that they are the parent/guardian of the above-named student.

Parent/Guardian Signature

Date

