Little Lion Bridge5

growing compassionate leaders

For Office Use Only

Date: ________________

Amount: ______________

Check #: ______________

STUDENT INFORMATION

________________________ ______________________ _________ ______________________

Student's Last Name Student's First Name Middle Initial Nickname (goes by)

Gender: __________ Birthday: ______/_______/_______ Age on September 1: __________

Race: ____American Indian ____Asian ____African American ____Hispanic ____Caucasian ____Other

____

Home mailing address

__________________________________ _____________ (_____)__________-_________________

City Zip Primary Phone #

ADDITIONAL STUDENT INFORMATION

Student Lives With (Please circle all that apply)

Both Parents Mother Father Step-Mother Step-Father Grandparents Other ________________

Parents are: ____Single ____Married ____Separated ____Divorced

Public School District in which you live: ____

PARENT/GUARDIAN INFORMATION

____

FATHER or GUARDIAN

____Same Address as Student

If address is different from student:

____

Address

____

City State Zip

________________ _______________________

Home Phone Cell Phone

____

Email

____

Employer/Occupation

____

Business Phone with Extension

____

Church Membership

____

MOTHER OR GUARDIAN

____Same Address as Student

If address is different from student:

____

Address

____

City State Zip

________________ _______________________

Home Phone Cell Phone

____

Email

____

Employer/Occupation

____

Business Phone with Extension

____

Church Membership

MISCELLANEOUS INFORMATION

Has your child ever had a hearing test?

If yes, when_______________ by whom__________________ Results________________

Has your child ever had an eye examination?

If yes, when_______________ by whom__________________ Results________________

Has your child ever experienced difficulties in another school setting or other social environments?

____

SPECIAL EDUCATION SERVICES

____Speech or Language ____ADD ____ADHD ____Behavior or emotional concerns

____Any other learning or behavior concerns ____

____

STUDENT HEALTH

FOOD ALLERGIES: List all food allergies. If none please indicate "None"

____

MEDICINE ALLERGIES: List all allergies to medicine. If none please indicate "None"

____

OTHER ALLERGIES (environmental such as bee stings, pollen, etc.)

____

OTHER HEALTH CONCERNS

____Asthma ____Frequent ear infections ____Frequent headaches ____Epilepsy ____Nose Bleeds

Other:____

____YES ____NO Your child is able to take care of basic restroom necessities independently (buttoning pants, using restroom, washing hands, etc.,)

EMERGENCY/MEDICAL INFORMATION: In case of emergency please list your family physician, and preferred hospital along with emergency contacts (someone that does NOT reside at your address):

We give our consent for the school to use its own judgment in securing medical aid and ambulance service in case the parents cannot be reached: Yes No Preferred Hospital _________________________________

The school may apply first aid treatment until the family can be contacted: Yes No

Family Physician ____ **Office Phone** __________________

Emergency Contact Information (someone that does NOT reside at your address)

Name: _____________________________ Phone: __________________ Relationship: _____________________

Phone: __________________

Name: _____________________________ Phone: __________________ Relationship: _____________________

Phone: __________________