Central Square Central School District

Annual Student Information Verification Form

To be updated by a Parent or Guardian

Please review the current information on file for your child.

Return to your child's school within 2 weeks **(ONLY IF THERE ARE CHANGES)**

Student Name: _____ Student ID: _____

School: _____ Homeroom: _____

Date of Birth: _____

Student Address: _____ ☐ Check if residential address is temporary
(of Residence)

_____ Student Home Phone: _____

Mailing Address: _____ Student's Personal Cell: _____
(if different)

CONTACT 1 *(PARENT/GUARDIAN)*

Parent/Guardian: _____ Custody: Yes / No Student lives with: Yes / No

Primary Contact Yes / No (Called First)

Relationship: _____ Can Pick Up? Yes / No Receives Mailings: Yes / No

Address: _____ Mailing Address: _____

_____

Employer: _____ Email: _____

		Call Order
Landline (Home) Phone:	_____	1 2 3
Cell Phone:	_____	1 2 3
Work Phone:		1 2 3

CONTACT 2 *(PARENT/GUARDIAN)*

Parent/Guardian: _____ Custody: Yes / No Student lives with: Yes / No

Primary Contact Yes / No (Called First)

Relationship: _____ Can Pick Up? Yes / No Receives Mailings: Yes / No

Address: _____ Mailing Address: _____

_____

Employer: _____ Email: _____

		Call Order
Landline (Home) Phone:	_____	1 2 3
Cell Phone:	_____	1 2 3
Work Phone:	_____	1 2 3

Student Name:	

ADDITIONAL CONTACT

Last Name, First Name: _____ Student lives with: Yes / No
Relationship: _____ Can Pick Up? Yes / No Receives Mailings: Yes / No

Address: _____ Mailing Address: _____

Employer: _____ Email: _____

		Call Order
Landline (Home) Phone:	_____	1 2 3
Cell Phone:	_____	1 2 3
Work Phone:	_____	1 2 3

ADDITIONAL CONTACT

Last Name, First Name: _____ Student lives with: Yes / No
Relationship: _____ Can Pick Up? Yes / No Receives Mailings: Yes / No

Address: _____ Mailing Address: _____

Employer: _____ Email: _____

		Call Order
Landline (Home) Phone:	_____	1 2 3
Cell Phone:	_____	1 2 3
Work Phone:	_____	1 2 3

ADDITIONAL CONTACT *(Optional)*

Last Name, First Name: _____ Student lives with: Yes / No
Relationship: _____ Can Pick Up? Yes / No Receives Mailings: Yes / No

Address: _____ Mailing Address: _____

Employer: _____ Email: _____

		Call Order
Landline (Home) Phone:	_____	1 2 3
Cell Phone:	_____	1 2 3
Work Phone:	_____	1 2 3

Student Name:	

Contact Call Order

Please verify the order we should call if we need to contact someone about this student. Contacts are listed in the order that we would call. If you would like us to call in a different order, please re-number them.

Current Call Order	Contact Name	Change Call Order To	Delete This Contact
1			
2			
3			
4			
5			
6			

Custody Information

Court-issued documents regarding custody or guardianship should be on file in the school your child attends. Remember, we **cannot** enforce custody arrangements if we do not have these documents on file.

Are custody documents on file: ☐ Yes ☐ No If you are not sure, please send in most up-to-date paperwork.

Regarding which child(ren)? _____

Emergency Closing Information

In the event of an emergency closing my child is to:

☐ Be dropped off at his usual stop

☐ Take the bus to the following location: (**this person must be listed as a contact**)

Name: _____ Contact Number: _____

Address: _____ Bus #: _____

I have spoken to my child and he/she knows what to do in the event of an emergency closing.

Other Children in Household (Not School Age)

Last Name, First Name: _____ Date of Birth (mm/dd/yyyy): _____

Last Name, First Name: _____ Date of Birth (mm/dd/yyyy): _____

Active Military/Reservist Information

Please let us know if you are currently on active duty in the armed forces or active duty reserves. For reporting requirements of ESSA (*Every Student Succeeds Act*), we are asked to track this information.

Start Date: _____ Anticipated End Date: _____

Parent/Guardian Name: _____ Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____

CENTRAL SQUARE CENTRAL SCHOOL DISTRICT

STUDENT HEALTH HISTORY UPDATE

Name:	DOB:	Grade:	☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Ph:		Date:
	Cell Ph:		

Contact name and number if your child becomes ill or injured during school hours:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalized	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD: *(Provide doctor's documentation)*

☐ ADHD	☐ Diabetes	☐ Heart Conditions	☐ Single Organ (☐kidney, ☐testicle)
☐ Asthma/trouble breathing	☐ Ear Infections	☐ High Blood Pressure	☐ Skin Condition
☐ Autism/Asperger	☐ GI Conditions (ulcer, reflux, IBS)	☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)	☐ Speech Condition
☐ Dental Injuries	☐ Headaches/migraines	☐ Scoliosis	☐ Urinary Condition

Please be aware that a doctor's order is required for all prescription and over the counter medication given at school.

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐ crutches ☐ walker ☐ wheelchair ☐ other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐ insulin/blood glucose monitoring ☐ inhaler/nebulizer/peak flow monitoring ☐ special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐ No ☐ Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

_____

NYS law requires a health examination for all students **entering the school district for the first time and when entering Pre-K, K, 1st, 3rd, 5th, 7th, 9th and 11th grade**. Your personal physician or the school physician may do health examines.
Please indicate your preference: ☐ Personal Physician ☐ School Physician

The above information may be shared with appropriate school personnel.

Parent/Guardian Signature: _____ Date: _____

Print Name of Parent/Guardian: _____