Please print. If information changes during the school year, please call or write the school office.

PUPIL INFORMATION CARD

Student's Full Name _____ _____ _____
(Last) (First) *(Middle)*

Date of Birth ____/____/____

The phone and address information has changed from last year ☐ Yes ☐ No

Home Phone # (____) _____-_____ Email Address: _____

PARENT EMAIL

Street Address _____ Apt. # _____
City _____ Zip Code _____-____

Grade _____ Home Room Teacher _____ School Bus # _____

Parent Status *(circle one)*: Married Separated Divorced Single Other

Mother/Guardian Name _____ Home Phone # (____) ____-_____
Street Address _____ Apt. # _____
City _____ Zip Code _____-____ Cell Phone # (____) ____-_____
Place of Employment _____ Phone # (____) ____-_____

Father/Guardian Name _____ Home Phone # (____) ____-_____
Street Address _____ Apt. # _____
City _____ Zip Code _____-____ Cell Phone # (____) ____-_____
Place of Employment _____ Phone # (____) ____-_____

FIRST NAME

Name and grade of brothers and sisters in Buckeye Schools:
Name: _____ Grade: _____ School: _____
Name: _____ Grade: _____ School: _____
Name: _____ Grade: _____ School: _____
Name: _____ Grade: _____ School: _____

In case of illness or emergency and we are unable to reach you, please list whom we may contact. *(If stepparents are to be included, please also specify.)*
Name: _____ Phone #: (____) ____-_____
Name: _____ Phone #: (____) ____-_____
Name: _____ Phone #: (____) ____-_____
Name: _____ Phone #: (____) ____-_____

Comments/Concerns: _____
_____
_____

LAST NAME

Do you wish to have your child's name/address/phone number listed in the school/student directory?
☐ Yes ☐ No

(Please complete and sign either Part I or Part II on the reverse side)

Please print. Complete either Part I or Part II. If information changes during the school year, please call or write the school office.

Part I Consent

School: _____

EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name _____ Address _____ Date of Birth ____/____/____

Telephone # (____) _____-_____

Residential Parent/Guardian:

Mother's Name _____ Daytime Phone # (____) _____-_____

Father's Name _____ Daytime Phone # (____) _____-_____

Other name of relative or childcare provider:

Name _____ Daytime Phone # (____) _____-_____

Relationship _____

I hereby give my consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone (____) _____-_____

Dentist _____ Phone (____) _____-_____

Medical Specialist _____ Phone (____) _____-_____

Local Hospital _____ Phone (____) _____-_____

Statement regarding consent when contact is unsuccessful:

If contact is unsuccessful, I give my permission for the appropriate personnel to treat my child in the following manner: _____

Special medical history, including allergies my child has: _____

____/____/____ _____ _____

Date *Signature* *Address*

Part II Refusal to Consent

I do not give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish to school authorities to take the following action:

_____

____/____/____ _____ _____

Date *Signature* *Address*