School Year: **16-17**

WESTERLY PUBLIC SCHOOLS

Student Information Verification Form

STUDENT INFORMATION

Last Name:	**First Name**:	**Student ID**:
Gender:	**Birthdate**:	**Current Grade**:
School Name: **WESTERLY HIGH**	**Teacher Name**:	**Homeroom**:

PRIMARY RESIDENCE INFORMATION

Home Address:	**Home Phone**:

CONTACT INFORMATION **Please list **both** biological parents unless court documents are provided otherwise.

Biological Parents or Legal Guardians only:

1)	**Relationship**:	2)	**Relationship**:
Address:		Address:	
Phone:	Home	Phone:	Home
Phone:	Cell	Phone	Cell
Phone	Work	Phone	Work
Email:		**Email**:	

If your home phone is your cell phone, please put the same telephone number for both.

ADDITIONAL EMERGENCY CONTACTS (i.e.: stepparents, other relatives, friends or neighbors) **LIMIT TO 3**

Please note, in addition to Parents/Guardians, ONLY the following adults may be notified and are authorized to accept responsibility for this child in case of illness/emergencies. This list will be shared with our nursing staff and transportation department.

3**Name**:	**Phone**:	Home	**Relationship**:
	Phone:	Cell	
	Phone:	Work	
4**Name**:	**Phone**:	Home	**Relationship**:
	Phone:	Cell	
	Phone:	Work	
5**Name**:	**Phone**:	Home	**Relationship**:
	Phone:	Cell	
	Phone:	Work	

If your child has any siblings who currently attend Westerly Public Schools, please list below:

Name	**Grade**	**School**

______________________________________ ______________________________

Parent/Guardian Signature **Date**

>>> PLEASE COMPLETE BOTH SIDES OF THIS FORM <<<

STUDENT HEALTH INFORMATION

Student Name: ____

Physician's Name	Phone	Date of Last Physical Exam

Please indicate if your child is receiving treatment for any medical conditions:

Allergic to Bee Stings:	Reaction:	Epi Pen: Yes ___ No___
Allergies (other than above): Y or N	To What:	Epi Pen: Yes ___ No___
Orthopedic:	Hearing Problems:	Epilepsy:
Vision Problems:	Glasses, Contacts, Safety Glasses	Heart Problems
Asthma: Yes ___ No___	**Inhaler Use: Yes ___ No___	How Often Used:

****If inhaler is required for school use, Physician Authorization for Medication to be taken during school hours form is REQUIRED**.

If your child rides the bus and has any condition the bus driver should be aware of, please indicate here: ___________ ____.

Describe any conditions and present treatment, including medications, restrictions, etc... that your child may be experiencing: ____

IBUPROFEN/TYLENOL/BENADRYL AUTHORIZATION

Grades 5-12

I give permission for the School Nurse to administer Tylenol (325 mg. 1 or 2) or Ibuprofen (200 mg. 1 or 2) to my child in the event they should request it.

Parent/Guardian Signature: ______________________________________ Yes ___ No ___

Grade K-12

I give permission for the School Nurse to administer Benadryl orally, following standing order protocol, in the event of a mild reaction.

Parent/Guardian Signature: ______________________________________ Yes ___ No ___