

SCHOOL _____ **CABOT PUBLIC SCHOOLS EMERGENCY FORM** PLEASE USE BLUE OR BLACK INK

GRADE _____ HOMEROOM TEACHER/ADVISOR _____ TEAM _____ GENDER **(CIRCLE)** MALE / FEMALE

BUS RIDER _____ BUS NUMBER _____ CAR RIDER _____ WALK HOME _____ DAYCARE _____

NAME _____ DATE OF BIRTH _____
(FIRST) (MIDDLE) (LAST) (NAME TO BE CALLED) MONTH / DAY / YEAR

ENROLLMENT DATE _____ SOCIAL SECURITY NUMBER (OR ASSIGNED NUMBER) _____

IS THIS STUDENT HISPANIC OR LATINO? **(CIRCLE)** YES NO

RACE **(CIRCLE ONE OR MORE IF APPLICABLE)** WHITE BLACK HISPANIC ASIAN / PACIFIC ISLANDER AMERICAN INDIAN / ALASKAN

CITY AND STATE OR COUNTRY OF BIRTH _____

MAILING ADDRESS _____ CITY _____ ZIP _____

911 ADDRESS (IF DIFFERENT FROM ABOVE) _____ CITY _____

DIRECTIONS TO HOME FROM SCHOOL _____

_____ MILES FROM SCHOOL _____

ARE THERE ANY **LEGAL** RESTRICTIONS WHICH WOULD PREVENT YOUR CHILD FROM BEING CHECKED OUT BY A PARTICULAR ADULT? **(CIRCLE ONE)** YES NO IF YES, PLEASE PROVIDE THE OFFICE WITH THE LEGAL DOCUMENTS.

STUDENT LIVES WITH (CIRCLE ONE)	BOTH PARENTS	MOTHER ONLY	FATHER ONLY	FOSTER PARENT
	LEGAL GUARDIAN	MOTHER/STEP-FATHER	FATHER/STEP-MOTHER	OTHER
LEGAL GUARDIANSHIP (CIRCLE ONE)	BOTH PARENTS	MOTHER ONLY	FATHER ONLY	OTHER

LIST PARENT / GUARDIAN WITH WHOM STUDENT LIVES

PARENT/GUARDIAN NAME		EMPLOYER
ADDRESS (IF DIFFERENT FROM ABOVE)		OCCUPATION
HOME PHONE	CELL PHONE	WORK PHONE
PARENT/GUARDIAN NAME		EMPLOYER
ADDRESS (IF DIFFERENT FROM ABOVE)		OCCUPATION
HOME PHONE	CELL PHONE	WORK PHONE

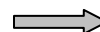
NAMES AND AGES OF OTHER CHILDREN LIVING IN HOUSEHOLD

EMERGENCY INFORMATION

PLEASE LIST OTHER PEOPLE WE CAN CONTACT IN THE EVENT THE ABOVE ARE UNAVAILABLE.

NAME		RELATIONSHIP TO STUDENT
HOME PHONE	CELL PHONE	WORK PHONE
NAME		RELATIONSHIP TO STUDENT
HOME PHONE	CELL PHONE	WORK PHONE

PLEASE COMPLETE OTHER SIDE



HEALTH QUESTIONNAIRE: CHECK CONDITIONS THAT APPLY TO YOUR CHILD-DESCRIBE UNDER COMMENTS

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Cardiac problem	<input type="checkbox"/> Headaches	<input type="checkbox"/> Orthopedic problem
<input type="checkbox"/> Anxiety/Panic attack	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hearing problem	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney/Urinary problem	<input type="checkbox"/> Seizures
<input type="checkbox"/> Bee Sting Allergy	<input type="checkbox"/> Epi-Pen	<input type="checkbox"/> Lung condition	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Behavior problem	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Muscle disorder	<input type="checkbox"/> Vision problem
<input type="checkbox"/> Bowel problem	<input type="checkbox"/> Food Allergy	<input type="checkbox"/> Neurological problem	<input type="checkbox"/> Other (Explain):

COMMENTS

(PLEASE CIRCLE **YES** OR **NO**): DOES YOUR CHILD WEAR GLASSES? **YES / NO** CONTACT LENSES? **YES / NO**

HAS YOUR CHILD HAD CHICKEN POX DISEASE? **YES / NO** APPROXIMATE DATE OR AGE _____

VARICELLA (CHICKEN POX) VACCINE? **YES / NO** (IF YES, PLEASE PROVIDE SHOT RECORDS)

DOES YOUR CHILD HAVE HEALTH INSURANCE? **YES / NO** IF NO, PLEASE SEND ME INFORMATION ABOUT ARKids 1ST **YES / NO**

DOES YOUR CHILD HAVE ALLERGIES TO ANY MEDICATION? **YES / NO** LIST: _____

DOES YOUR CHILD HAVE ANY ENVIRONMENTAL ALLERGIES? **YES / NO** LIST: _____

IS YOUR CHILD ON ANY MEDICATION WE NEED TO BE AWARE OF? **YES / NO** LIST: _____

DOCTOR'S NAME _____ PHONE _____ PREFERRED HOSPITAL _____

RELEASE OF INFORMATION: I, THE PARENT OR LEGAL GUARDIAN, GIVE MY PERMISSION FOR THIS INFORMATION TO BE SHARED WITH SCHOOL STAFF OR EMERGENCY MEDICAL PERSONNEL ON A "NEED TO KNOW BASIS" DURING THE CURRENT SCHOOL YEAR.

DO YOU LIVE IN FEDERALLY FUNDED LOW-RENT HOUSING? (CIRCLE ONE) **YES NO**

IS EITHER PARENT/GUARDIAN AN EMPLOYEE OF THE UNIFORMED MILITARY SERVICES? (CIRCLE ONE) **YES NO**

IS EITHER PARENT/GUARDIAN AN EMPLOYEE OF THE LRAFB CIVILIAN SERVICE, McCLELLAN VA MEDICAL CENTER, PINE BLUFF ARSENAL, TOWBIN HEALTHCARE, CAMP ROBINSON, OR FEDERAL OFFICE BUILDING? (CIRCLE ONE) **YES NO**

PRIMARY LANGUAGE SPOKEN AT HOME _____

PRIMARY LANGUAGE STUDENT SPEAKS _____

PRIMARY LANGUAGE PARENTS SPEAK _____

CORPORAL PUNISHMENT **MY CHILD IS TO BE EXCLUDED FROM CORPORAL PUNISHMENT.**
(CHECK ONE)

MY CHILD IS SUBJECT TO ALL DISCIPLINE POLICIES - PARENT WILL BE CONTACTED.

DOES THE STUDENT REQUIRE SPECIAL SERVICES? IF YES, CIRCLE ALL THAT APPLY:

SPEECH ESL RESOURCE INCLUSION 504 PLAN GIFTED AND TALENTED

NAME, ADDRESS, AND PHONE NUMBER OF LAST SCHOOL ATTENDED _____

WAS ENROLLEE PROMOTED TO THE NEXT GRADE? (CIRCLE ONE) **YES NO**

HAS ENROLLEE EVER BEEN RETAINED? (CIRCLE ONE) **YES NO**

IF YES, WHICH SCHOOL AND DISTRICT? _____

IS ENROLLEE CURRENTLY UNDER A LONG-TERM SUSPENSION/EXPULSION FROM HIS/HER PREVIOUS SCHOOL OR IS AN EXPULSION CONFERENCE PENDING? (CIRCLE ONE) **YES NO**

HAS ENROLLEE EVER BEEN ENROLLED IN THE CABOT SCHOOL DISTRICT? (CIRCLE ONE) **YES NO**

IF YES, WHICH SCHOOL IN CABOT DID HE/SHE LAST ATTEND? _____

DO YOU HAVE ACCESS TO A COMPUTER? (CIRCLE ONE) **YES NO** DO YOU HAVE ACCESS TO THE INTERNET? **YES NO**

E-MAIL ADDRESS _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____

IT IS THE LAW: ACT 663 – SECTION (5) (H) ANY PERSON WHO KNOWINGLY GIVES A FALSE RESIDENTIAL ADDRESS FOR THE PURPOSES OF PUBLIC SCHOOL ENROLLMENT IS GUILTY OF A MISDEMEANOR AND SUBJECT TO A FINE