2011-12

Sky Islands High School

Student Registration & Emergency Information

Student Name ____ DOB _______________ Cell Phone __________________

Student E-mail ____ Parent E-mail ___________________________________

Parent/Guardian __________________________________ (H) _______________ (C)_______________ (W) _______________

Address ____ City _______________ State_____ ZIP ______________

Name of Employer/Company ____

Parent/Guardian __________________________________ (H) _______________ (C)_______________ (W) _______________

Name of Employer/Company ____

Interested in Volunteer Work? ___Yes ___No

Is the student **currently** enrolled in programs such as Special Education, Gifted/GATE programs, Etc.?

__YES __ NO If YES please explain: ____

Has the student **previously** been enrolled in Special Education, Gifted/GATE programs, Etc.?

__YES __ NO If YES please explain: ____

Has the student been diagnosed with a serious or disabling condition that may require/ has required accommodation or evaluation for Special Education (504 Plan)? **(A copy of the diagnosis must be provided.)**

__YES __ NO If YES please explain: ____

Is the student currently/ or has the student ever been under the supervision of the Juvenile Court for prior criminal activity?

__YES __ NO If YES please explain: ____

Name of Probation Officer:____ Contact Phone: _____________________

Name of Case Worker: ____ Contact Phone: _____________________

Has the student ever been expelled or suspended long term from any previous schools s/he attended?:

__YES __ NO If YES please explain: ____

Emergency Contact ________________________________ (H) _______________ (C) _______________ (W)_______________

Emergency Contact ________________________________ (H) _______________ (C) _______________ (W)_______________

Primary Care Physician____ **Phone** ______________________________

Name of Hospital____ **Phone** ______________________________

Drug Allergies_________________________ Prescribed Medications being Taken ________________________________

Present/Known Medical Conditions____

Sky Islands personnel will not administer medication brought from home, including over-the-counter medication, unless there is a written prescription from a Health Care Provider. The medication must be in the original container with the student's name and dosage information listed. ALL medications must be kept in the front office at all times. Provisions for asthma inhalers to be carried by the student may be made when the student is required to leave the school site for a school activity provided it is accompanied by a doctor's note.

Please check the listed over-the-counter medications that you give permission for your child to receive from Sky Islands' staff:

__Tylenol (Acetaminophen) ___Advil (Ibuprofen) ___ Tums (Antacid) ___Anti-itch Cream/Lotion

__Saline eye wash (for eye irritation) __Throat Lozenges/Cough Drops __Triple Antibiotic Ointment (Neosporin)

I hereby authorize Sky Islands High School to obtain medical care in the event that an emergency occurs. Sky Islands High School will make every effort to reach the emergency contacts listed above. I understand it is the responsibility of the parent/guardian to keep the school updated if any emergency information listed above changes.

____ ______________________________

Parent/Guardian Signature **Date**