SOUTH SHORE EDUCATIONAL COLLABORATIVE
Student Information Sheet

Student Name: _____Ethnicity:_____Date of Birth:_____
Address: _____ Town:_____ Zip Code:_____
Student Cell Phone:_____ Student SSN# (optional) _____

Parent/Guardian #1: Name: _____ Relationship: _____
Address if different from student_____
Phone #1:_____Cell___Home___Work___Permission to LVM___
Phone #2:_____Cell___Home___Work___Permission to LVM___
Phone #3:_____Cell___Home___Work___Permission to LVM___
Parent/Guardian #1 Email: _____

Parent/Guardian #2: Name_____Relationship: _____
Address if different from student_____
Phone #1:_____Cell___Home___Work___Permission to LVM___
Phone #2:_____Cell___Home___Work___Permission to LVM___
Phone #3:_____Cell___Home___Work___Permission to LVM___
Parent/Guardian #2 Email: _____

If student does not reside with parents, name of responsible agency and/or foster home:

Emergency Contacts: Please fill in both sections completely. You must provide us with 2 names of friends or relatives who have transportation available.

1. Name: _____Phone:_____
Address: _____ Relationship: _____
2. Name: _____Phone:_____
Address: _____ Relationship: _____

I give my consent in an emergency for the program to seek nearby medical care. I understand that every attempt will be made to reach me or the emergency contacts listed above.

***Signature*_____ Today's Date:_____**

Primary Care Physician_____
Address: _____ Phone:_____
Psychiatrist: _____ Phone:_____
Therapist: _____Phone:_____
Dentist: _____Phone:_____

Medical Health Plan and #: _____

Medications: Please list ALL medications your child is taking, how much and how often. Please notify us of any changes during the year_____
_____
_____
Please list any medical concerns and allergies: _____
_____
