

**PRESENTATION BVM SCHOOL**

STUDENT INFORMATION for \_\_\_\_\_ School Year

**(Please type or print)**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Room \_\_\_\_\_

Parents \_\_\_\_\_  
Father's Full Name \_\_\_\_\_ Mother's Full Name \_\_\_\_\_

Guardian \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_  
Parish \_\_\_\_\_ E-mail address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Father's Cell # \_\_\_\_\_ Mother's Cell # \_\_\_\_\_

Work # (Father) \_\_\_\_\_ Work # (Mother) \_\_\_\_\_

Father's Occupation \_\_\_\_\_

Place of Business & Address \_\_\_\_\_

Mother's Occupation \_\_\_\_\_

Place of Business & Address \_\_\_\_\_

**FOR CASES OF EMERGENCY, PLEASE FILL IN THE FOLLOWING:**

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Persons to contact if you can't be reached (Must have at least 1 name)

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Please note any special health conditions such as an allergy to any medication (antibiotics, tetanus or adhesive sensitivity), to insect bites, convulsions, delayed blood clotting time, asthma, etc.

\_\_\_\_\_

I give permission for my child to be taken to the nearest hospital in an emergency if I cannot be reached.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>OFFICE USE ONLY</b>
_____ Tylenol card on file
_____ Medication in Nurse's office