Nestucca Valley 21st Century Community Learning Centers (NV21CCLC)
School Year _______________

STUDENT INFORMATION

Student Name:	Date of Birth:
Grade:	Male Female
Address:	City:
State: Zip:	School:

Ethnicity: 1. American Indian/Alaska Native 2. Black/African American 3. Hispanic/Latino 4. Asian 5. White 6. Pacific Islander 7. Other

Language(s) spoken at home:

PARENT/GUARDIAN INFORMATION

Name of Primary Parent/Guardian 1.

Guardian Title (circle one) Mother Father Grandmother Grandfather Other ____________

Language(s) spoken at home:

Home Phone:	Work Phone:
Cell Phone:	Email:

Name of Primary Parent/Guardian 2.

Guardian Title (circle one) Mother Father Grandmother Grandfather Other ____________

Language(s) spoken at home:

Home Phone:	Work Phone:
Cell Phone:	Email:

PERSON(s) NOT AUTHORIZED TO PICK-UP STUDENT OR RECEIVE STUDENT INFORMATION

Name: ____________________________Relationship: Restraining Order: YES* NO

Name: ____________________________Relationship: Restraining Order: YES* NO

* If you answer yes, please provide a copy of the Restraining or Court Order to the school.

EMERGENCY INFORMATION	
Parent/Guardian will be called first in the event of an emergency. Please list additional individuals who can be contacted to assume temporary care of your child in the even you cannot be reached.	
Name:	Relationship:
Address:	Home Phone:
Employer:	Work Phone:
e-mail:	Cell Phone:
Name:	Relationship:
Address:	Home Phone:
Employer:	Work Phone:
e-mail:	Cell Phone:

STUDENT MEDICAL INFORMATION	
Doctor Name:	Phone:
Dentist Name:	Phone:
Hospital Preference:	Phone:
Med. Insurance Co.:	Policy Number:
	Group Number:
If your child needs to have medication while at NV21CCLC, please see the School Office Manager for the appropriate forms.	

SEVERE ALLERGIES:

Type of Allergy (i.e. bee stings, food, etc...) **Immediate Medication Required?:**

_______________________________________ Yes ____ No ____

_______________________________________ Yes ____ No ____

Please check type of medication: Epi Pen __________ Oral Medication ______ Type: _____________

Any other health concerns? Asthma _______ Heart _______Seizures _______ Diabetes_______

I, the undersigned, do hereby authorize officials of Nestucca Valley School District to contact directly the persons named on this form, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of the child. In the event physicians, other persons named on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary, in their judgement, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent/Guardian/Eligible Student:________________________________ Date___________

(Eligible student indicates any student that is 18 years or older, or emancipated.)

I give my child ___________________________ permission to enroll and participate in the Nestucca Valley 21st Century Community Learning Centers Program in Nestucca Valley School District.

_____________________________ _____________________________ ______________

(Print) Parent/Guardian Name Parent/Guardian Signature Date