Ivywood Classical Academy
STUDENT INFORMATION RECORD

Name of Child (Last, First, Middle Initial)			Child's Date of Birth
Address (Number and Street, Building/Apartment Number)	City	State	Zip Code

Parent/Legal Guardian's Name	Home Phone ( )	Parent/Legal Guardian's Name (Optional)	Home Phone ( )
Home Address (if not child's address)	Cell Phone ( )	Home Address (if not child's address)	Cell Phone ( )
City / State / Zip Code		City / State / Zip Code	
Email Address (optional)		Email Address	
Employer Name	Work Phone ( )	Employer Name	Work Phone ( )

Child Resides with (Circle One): MOTHER FATHER BOTH PARENTS LEGAL GUARDIAN

Name of Child's Physician or Health Clinic

Hospital Preferred for Emergency Treatment (optional)	Physician's or Health Clinic's Phone Number ( )

Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	**( )**	**2.**	**( )**
3.	**( )**	**4.**	**( )**

Parent/Legal Guardian Initials:

_____I give permission to _____, to secure emergency medical treatment for the above named minor child while in care.

Physician authorization required if medication is administered at school. See Student Handbook. Health information provided on this form and information submitted on physical health appraisals may be shared with school personnel who are involved with health and safety of your child. If school personnel are unable to reach me or a person who I have designated, I hereby authorize the school to secure emergency medical treatment as necessary. I agree to pay all expenses incurred by the emergency care. **Parent or Guardian Initials:**

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Guardian Initials Parent or Legal