## Additional Student Information
**(Prekindergarten, Kindergarten, and All New Enrollments)**

WCPS | Washington County Public Schools

| Student's Name: | Grade: | School: | Birth Date: |
|---|---|---|---|

**Emergency/Temporary Care Contact Information:** **List a minimum of three adults who may assume temporary care of your child without your further consent, in the event of an emergency, illness or accident when you cannot be reached. In the event of a non-emergency circumstance, such as an appointment, a parent/guardian must provide the school with additional written consent to identify the adult who has permission to pick up the student, for each occasion. PLEASE IDENTIFY CHILDCARE PROVIDER.**

| Name | Relationship to Student | Home Number | Work Number | Cell Number |
|---|---|---|---|---|
| | | | | |
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**Release of Information:** **The Family Educational Rights and Privacy Act (FERPA) requires that WCPS obtain the written consent of parents/guardians, prior to the disclosure of personally identifiable information from the student's record to anyone other than the legal parent/guardian.**

**High School Students: Release of Information to Military Recruiters**
Under Federal Law, public school districts must release the names, addresses, and telephone numbers of 9th through 12th grade students to U.S. military recruiters. The student or parent has the right to request in writing that this information NOT be released. If you do not want this information released, please check box.

☐ DO NOT release information to MILITARY RECRUITERS

**Media Access**
In the course of school activities, WCPS staff and/or the news media occasionally wish to interview, photograph, or videotape students, display their work or publish their names. Unless indicated otherwise below, WCPS will assume permission to do so. WCPS cannot control media coverage of events that are open to the public.

☐ DO NOT release information about or allow media access to my child. Checking this box does not pertain to photos taken for the school yearbook.

**Directory Information:**
Certain information that is not considered harmful or an invasion of privacy is referred to as Directory Information and may be disclosed to outside organizations without parent/guardian consent, unless the parent/guardian indicates to the contrary. Outside organizations include, but are not limited to, companies that manufacture class rings or publish yearbooks. Parents/guardians who do not want Directory Information released to outside organizations must complete the Restriction of Access to Directory Information Annual Parental Opt-Out Form available at each Washington County public school and return within 10 days from the first day of school or within 10 days of initial enrollment. (See *WCPS Handbook and Guide* for information.)

I authorize the release of confidential medical student information, including medical and psychological records concerning my child, to the Washington County Board of Education, its authorized representatives, my child's health care provider and to state and local governmental agencies such as the health department. ☐ DO NOT release information.

**Parent/Guardian Signature:** _____ **Date:** _____

**Health Care Information**

| Health Care Provider/Physician: | Phone: |
|---|---|
| Dentist: | Phone: |
| Health Insurance Company: ☐ Private (Name of Company) | ☐ MCHIP ☐ No Insurance |

**Check if your child has any of the following:**

| Medications(s) | | Allergies | |
|---|---|---|---|
| Check those that apply. | Indicate name of medication. | Check those that apply. | Describe allergic reaction. |
| ☐ Asthma | Medication: | ☐ Food* | |
| ☐ Attention Deficit | Medication: | ☐ Chemicals/Environmental | |
| ☐ Diabetes | Medication: | ☐ Bee Sting/ Insect Bites | |
| ☐ Heart Problems | Medication: | ☐ Latex | |
| ☐ Migraines | Medication: | ☐ Medicines | |
| ☐ Mental Health | Medication: | | |
| ☐ Seizure Disorders | Medication: | | |
| ☐ Other | Medication: | | |
| Is medication administered at school? ☐ Yes ☐ No | | Is epi-pen used? ☐ Yes ☐ No | |
| Is medication administered at home? ☐ Yes ☐ No | | Has breathing been affected? ☐ Yes ☐ No | |
| Recent surgery, accident, or illness? ☐ Yes ☐ No If yes, describe: | | | |

*if a student has food allergies, the *Special Dietary Needs for Student Form* must be completed.

**Student's Medical History**

| | | |
|---|---|---|
| ☐ Anorexia/Bulimia (Eating Disorder) | ☐ Headaches – Frequent | ☐ Sore Throats – Frequent |
| ☐ Dental Problem | ☐ Hearing Problem – Wears Aids | ☐ Speech Problems |
| ☐ Disability – Physical | ☐ Heart Condition | ☐ Stomachaches – Frequent |
| ☐ Earaches – Frequent | ☐ Kidney/Bladder Problems | ☐ Vision Problem – Wears Glasses/Contacts |
| ☐ Eczema (Skin Disorder) | ☐ Menstrual Problems | ☐ Other: _____ |
| ☐ Fainting Spells | ☐ Orthopedic Condition | ☐ Other: _____ |
| ☐ Gastrointestinal Disorder | ☐ Seizure Disorder | |

List any other information regarding your child's health that will help the school staff to better understand and work with your child.

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☐ In the event my child requires medical treatment, I authorize the Washington County Public Schools and its authorized representatives to provide medical treatment.

**Parent/Guardian Signature** _____ Date: _____