

**ACADEMY LEARNING CENTER
PUPIL INFORMATION FORM
2020 - 2021 School Year**

PLEASE print all information

Date: _____

Student's Name: _____ Date of Birth: _____

Address: _____
Street City/Town Zip Code

Home Telephone #: _____ Email: _____

Mother's Name: _____ Work Tele. #: _____

Cell Phone #: _____ Hours at work: _____

Father's Name: _____ Work Tele: #: _____

Cell Phone #: _____ Hours at work: _____

We will **e-mail** information about our school such as PTO announcements, relevant workshops, meal account, etc. to parents/guardians by e-mail this year. Please provide at least one e-mail address for this purpose below.

EMERGENCY CONTACT PERSON (Required): Please designate two family members or friends that can be contacted in the event of **student injury or illness** when the parents cannot be reached. These persons are authorized to pick up my son/daughter at school.

1. Name: _____ Relationship: _____ Tele: _____

2. Name: _____ Relationship: _____ Tele: _____

Does your son/daughter have Health Insurance?

Yes _____ Health Care Insurer is _____
No _____ (Would you like information about NJ Family Care? _____)

It is important that our Health Office be kept current on the medications that our students are taking. Please list any medication(s) given at home (attach separate page if necessary)

Type: _____ Dose: _____ Times: _____

Type: _____ Dose: _____ Times: _____

Please list any allergies (food, medication, insect bites, etc.) that your son/daughter has:

Name of Pediatrician: _____ Tele #: _____

Name of Neurologist: _____ Tele #: _____

Name of Dentist: _____ Tele #: _____

Other: _____ Name: _____ Tele #: _____

Thank you for completing this form. If the information changes, please notify the school office.