ACADEMY LEARNING CENTER
PUPIL INFORMATION FORM
2019-20 School Year

PLEASE print all information Date: _____

Student's Name: _____ Date of Birth: _____

Address: _____
Street City/Town Zip Code

Home Telephone #: _____

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

Cell Phone #: _____ E-Mail: _____

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

Cell Phone #: _____ E-Mail: _____

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? □ Yes □No)

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: _____

Type: _____ Dose: _____ Times: _____

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

Medical Contacts

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.