

**ACADEMY LEARNING CENTER  
PUPIL INFORMATION FORM  
2022 - 2023 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.*