

Student Information Form

Your Child's Information			
Name:		Date of Birth:	Gender:
Current School:	Current Grade Level:	Student ID No.:	Current School District:
Next Year's School (if different):		Next Year's School District (if applicable):	
Parent/Guardian Contact Information			
Parent/Guardian #1 Name:		Email Address 1:	
Street Address:		Occupation:	
City		State:	Zip Code:
Home Phone No.:		Additional Phone No.: <input type="checkbox"/> Office <input type="checkbox"/> Cell <input type="checkbox"/> Pager	
Parent/Guardian 2 Contact Information			
Parent/Guardian #2 Name:		Email Address 2:	
Street Address:		Occupation:	
City		State	Zip Code:
Home Phone No.:		Additional Phone No.: <input type="checkbox"/> Office <input type="checkbox"/> Cell <input type="checkbox"/> Pager	
Family Information			
Sibling Name:		Age:	Grade Level:
Sibling Name:		Age:	Grade Level:
Sibling Name:		Age:	Grade Level:
Ethnicity (Optional): Please check all that apply <input type="checkbox"/> Native American/ Alaskan Native <input type="checkbox"/> Asian/ Pacific Islander <input type="checkbox"/> Armenian <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> African American <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other: _____			

Other Information:	What skills do you hope your child practices at Community Works?

How did you find out about Community Works?	

Please complete other side

In case of emergency, I give Learning Works! permission to release my child to the following persons:

Emergency Contact (Individuals other than parents/guardians)		
Name:	Relation to Child:	
Phone Number:		
Name:	Relation to Child:	
Phone Number:		
Medical Information		
Insurance Group Name:	Group No.:	
Name of Family Doctor:	Phone:	
Street Address:		
City	State	Zip Code:

Date of Last Tetanus Injection or Booster: _____

Has your child been diagnosed with any of the following (check all that apply):

- Asthma Epilepsy Other (specify): _____
 Heart Disorder Diabetes None

Please list your child’s allergies below (e.g. bee stings and peanuts) or check None.

Does your child require regular medication? Yes No. If yes, please specify below.

Medical Consent	The undersigned hereby certifies that my child is in good health and can travel and participate in activities sponsored by Community Works (CW).
	While my child is attending or traveling to or from these activities, I hereby authorize the CW staff members or consultants to provide any of the following medical treatment for said minor.
	Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, or is to be rendered under the supervision of, any physician or surgeon licensed by the state of California. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and shall remain in effect from the date signed for the duration of my child’s participation in CW programs.
	Parent or Guardian Signature: _____ Date Signed: _____