

WESTERLY PUBLIC SCHOOLS
Student Information Verification Form

STUDENT INFORMATION

Last Name:	First Name:	Student ID:
Gender:	Birthdate:	Current Grade:
School Name: WESTERLY HIGH	Teacher Name:	Homeroom:

PRIMARY RESIDENCE INFORMATION

Home Address:	Home Phone:

CONTACT INFORMATION **Please list both biological parents unless court documents are provided otherwise.

Biological Parents or Legal Guardians only:

1)	Relationship:	2)	Relationship:
Address:		Address:	
Phone:	Home	Phone:	Home
Phone:	Cell	Phone:	Cell
Phone:	Work	Phone:	Work
Email:		Email:	

If your home phone is your cell phone, please put the same telephone number for both.

ADDITIONAL EMERGENCY CONTACTS (i.e.: stepparents, other relatives, friends or neighbors) **LIMIT TO 3**

Please note, in addition to Parents/Guardians, ONLY the following adults may be notified and are authorized to accept responsibility for this child in case of illness/emergencies. This list will be shared with our nursing staff and transportation department.

3Name:	Phone:	Home	Relationship:
	Phone:	Cell	
	Phone:	Work	
4Name:	Phone:	Home	Relationship:
	Phone:	Cell	
	Phone:	Work	
5Name:	Phone:	Home	Relationship:
	Phone:	Cell	
	Phone:	Work	

If your child has any siblings who currently attend Westerly Public Schools, please list below:

<u>Name</u>	<u>Grade</u>	<u>School</u>

Parent/Guardian Signature

Date

>>> PLEASE COMPLETE BOTH SIDES OF THIS FORM <<<

STUDENT HEALTH INFORMATION

Student Name: _____

<u>Physician's Name</u>	<u>Phone</u>	<u>Date of Last Physical Exam</u>

Please indicate if your child is receiving treatment for any medical conditions:

Allergic to Bee Stings:	Reaction:	Epi Pen: Yes ___ No ___
Allergies (other than above): Y or N	To What:	Epi Pen: Yes ___ No ___
Orthopedic:	Hearing Problems:	Epilepsy:
Vision Problems:	Glasses, Contacts, Safety Glasses	Heart Problems
Asthma: Yes ___ No ___	**Inhaler Use: Yes ___ No ___	How Often Used:

****If inhaler is required for school use, Physician Authorization for Medication to be taken during school hours form is REQUIRED.**

If your child rides the bus and has any condition the bus driver should be aware of, please indicate here: _____

Describe any conditions and present treatment, including medications, restrictions, etc., that your child may be experiencing: _____

IBUPROFEN/TYLENOL/BENADRYL AUTHORIZATION

Grades 5-12

I give permission for the School Nurse to administer Tylenol (325 mg. 1 or 2) or Ibuprofen (200 mg. 1 or 2) to my child in the event they should request it.

Parent/Guardian Signature: _____ Yes ___ No ___

Grades K-4

I give permission for the School Nurse to administer Acetaminophen (Tylenol) for a fever of 101 or greater. (dose based on wt.)

Parent/Guardian Signature: _____ Yes ___ No ___

Grade K-12

I give permission for the School Nurse to administer Benadryl orally, following standing order protocol, in the event of a mild reaction.

Parent/Guardian Signature: _____