VALLEY STREAM UNION FREE SCHOOL DISTRICT THIRTEEN

Contact Verification for Students

Surname: _____

Home Address: _____ Phone Number: _____

Student Name: _____ Gender: M___ F ___ School: _____ Grade:___ Date Entered District: ___/___/___

Parent/Guardian Information:

Parent/Guardian Name: _____ Relationship: _____ Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email Address: _____

Emergency Contacts – Please list at least two emergency contacts

Name	Relationship	Home Phone	Work Phone	Cell Phone	Address	Email Address

1.) _____

2.) _____

3.) _____

Student Allergies:

Any Known Allergies: _____ Allergy Reaction: _____

Does your child take medication on a regular? _____ Specify: _____

Other medical conditions: _____

Physician's Name: _____ Physician's Phone Number: _____

In case of an accident or serious illness, we will make effort to contact you and/or your emergency contacts. If unable to reach you, we will provide the emergency care deemed necessary. I give my permission for the school nurse to share health information with appropriate personnel.

Parent/Guardian: _____ Date: _____