ENROLLMENT/HEALTH CARD

NAME CHILD USES	LAST	FIRST	MIDDLE
FULL LEGAL NAME (IF DIFFERENT)	LAST	FIRST	MIDDLE
ADDRESS	STREET	CITY	ZIP

SCHOOL YEAR
2017-2018

IMMUNIZATION COMPLETE:
_____ YES _____ NO

OFFICE USE ONLY

OFFICE USE ONLY

TEACHER: ID:
BIRTH DATE VER: ROOM NO.:
RESIDENCY VER: GRADE:
WITHDRAWAL DATE: INST SETTING:
REG. PACKET: ORG ENT DATE:
IMM: LANGUAGE CODE:
ENTER DATE: ETHNIC CODE:

(AREA CODE) PHONE	UNLISTED	OK FOR PTA	GENDER	GRADE

BIRTH DATE	BIRTH CITY	BIRTH STATE	BIRTH COUNTRY	IF NOT US CITIZEN, DATE CHILD ENTERED US	FOREIGN BORN US CITIZEN AT BIRTH?	LANGUAGE SPOKEN IN THE HOME

CHILD RESIDES WITH:	BOTH PARENTS	MOTHER	FATHER	LEGAL GUARDIAN	OTHER	IF OTHER, PLEASE EXPLAIN

PARENT (PLEASE CIRCLE): NATURAL, STEP, OTHER - IF CHILD RESIDES WITH BOTH PARENTS, LIST MOTHER FIRST

IF PARENTS HAVE MORE THAN ONE ADDRESS, PLEASE INDICATE ADDITIONAL ADDRESSES ON BACK

NAME	RELATIONSHIP	EMPLOYER	(AREA CODE) BUSINESS PHONE	CELLULAR PHONE	EMAIL	OCCUPATION

NAME	RELATIONSHIP	EMPLOYER	(AREA CODE) BUSINESS PHONE	CELLULAR PHONE	EMAIL	OCCUPATION

LAST SCHOOL CHILD ATTENDED SABA ACADEMY ADDRESS 4415 FORTRAN CT CITY SAN JOSE STATE CA ZIP 99134 GRADE SPECIAL PROGRAM _____

HIGHEST EDUCATION LEVEL OF EITHER PARENT/GUARDIAN ☐ NOT A HIGH SCHOOL GRADUATE ☐ HIGH SCHOOL GRADUATE ☐ SOME COLLEGE ☐ BA/BS DEGREE ☐ GRADUATE SCHOOL/POST GRAD TRAINING ☐ DECLINE TO STATE

OTHER CHILDREN IN THE FAMILY (PLEASE LIST NAME, BIRTH DATE):

EMERGENCY INFORMATION: IF MY CHILD NEEDS TO LEAVE SCHOOL DUE TO ILLNESS, ACCIDENT, OR AN EMERGENCY AND I CANNOT BE REACHED, MY CHILD MAY BE RELEASED TO THE FOLLOWING:

(PLEASE SELECT A PERSON, OTHER THAN A PARENT, WHO WILL BE ABLE TO PICK UP YOUR CHILD DURING THE DAY) List child care provider first.

NAME	ADDRESS	(AREA CODE) PHONE	RELATIONSHIP
NAME	ADDRESS	(AREA CODE) PHONE	RELATIONSHIP
NAME	ADDRESS	(AREA CODE) PHONE	RELATIONSHIP

IN AN EMERGENCY, IF THE SCHOOL IS UNABLE TO REACH ME, I HEREBY GIVE MY CONSENT FOR TREATMENT TO BE GIVEN BY:

DOCTOR	ADDRESS	(AREA CODE) PHONE	CHILD'S MEDICAL ID NUMBER

DENTIST	ADDRESS	(AREA CODE) PHONE	ORTHODONTIST	(AREA CODE) PHONE

MEDICAL INFORMATION (INDICATE YES (Y) OR NO (N) IN EACH BOX

ON MEDICATION?	ALERGIC (MEDICATION)	HEARING PROBLEM	VISION PROBLEM	CONTACT LENSES	LIMITED ACTIVITY	SEIZURE DISORDER	HEART PROBLEM	DIABETES	ASTHMA	ALLERGY BEE STING	ALLERGY (OTHER)

IF ANY OF ABOVE ARE CHECKED OR IF YOU HAVE ANY MEDICAL INFORMATION THE SCHOOL SHOULD BE AWARE OF, PLEASE EXPLAIN:

IF THE PARENTS CANNOT BE REACHED, AND IT IS DETERMINED MY CHILD NEEDS EMERGENCY MEDICAL CARE, PLEASE TAKE MY CHILD TO THE NEAREST EMERGENCY AID STATION, BY AMBULANCE, IF NECESSARY, FOR TREATMENT.

Important Signature Required _____ _____ **Important Signature Required**

PARENT/GUARDIAN SIGNATURE

DATE