# Abbotts Hill Elementary 2020-2021 Student Information Card

**Student's Last Name:** **Student's First Name:** **Teacher:**

**Date of Birth: m/d/yy** **Sex: Male** ☐ **Female** ☐ **Preferred Name:**

**Address:**

**Home Phone:** **Subdivision/Complex:** **Bus # or Daycare Name:**

**Parent 1 Information**
**Parent 1 Last Name:** **Parent 1 First Name:** **Best Contact Number:**

**Address (if different than student):**

**Parent 2 Information**
**Parent 2 Last Name:** **Parent 2 First Name:** **Best Contact Number:**

**Address (if different than student):**

**Student Resides With:** ☐ Mother ☐ Father ☐ Stepfather ☐ Stepmother ☐ Legal Guardian

**List any Siblings at Abbotts Hill:**

## Emergency Contact/Pick Up Information (Please Read Carefully)

**EMERGENCY CONTACTS:** Please list individuals to whom your child may be released (other than yourself/spouse) in the order you wish them to be called. The school will contact the parent(s) listed above first. Please verify with persons listed below that they may be called in the event of a the child's illness or emergency in the event that we cannot contact the parents listed above.

**Emergency Contact #1 (will be called first):**

**Last Name:**

**First Name:**

**Relationship to Student:**

**Best Contact Number:**

**Emergency Contact #2 (will be called second):**

**Last Name:**

**First Name:**

**Relationship to Student:**

**Best Contact Number:**

**Medical Conditions - Check All That Apply**

| | | | | | |
|---|---|---|---|---|---|
| None | ☐ | Allergies - Seasonal | ☐ | Heart Problems | ☐ |
| Asthma | ☐ | Allergies - Food | ☐ | Nose Bleeds | ☐ |
| Cystic Fibrosis | ☐ | Allergies - Medication | ☐ | Diabetes | ☐ |
| Seizure Disorder | ☐ | Sickle Cell | ☐ | Other | ☐ |

***Daily Medication: If it is necessary for your student to take medications at school, the form Authorization to Give Medication Form (available on Fulton County Website) must be completed and submitted to the clinic. Parents should bring the medication and the form to the school clinic.*****

**Student Physician's Name:** **Physician's Phone:**

**I give permission for my child to have bug bites/rashes to be treated with cortisone cream (initial to give permission)**

**I give permission for my child to have cuts/scrapes treated with triple antibiotic ointment (initial to give permission)**

Parent Signature Below: Parents Email Address: Date: