

**Chancellor Academy - Student Information – please complete and return**

Student's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Social Security # \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_

Mother's Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

Workplace \_\_\_\_\_

Home telephone # \_\_\_\_\_

Work telephone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

Email Address: \_\_\_\_\_

Student Cell # \_\_\_\_\_

Father's Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

Workplace \_\_\_\_\_

Home telephone # \_\_\_\_\_

Work telephone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

Email Address: \_\_\_\_\_

**Emergency Contact – person who will assume temporary care of your child if you can not be reached:**

1<sup>st</sup> Name \_\_\_\_\_ Telephone # \_\_\_\_\_ Relationship \_\_\_\_\_

2<sup>nd</sup> Name \_\_\_\_\_ Telephone# \_\_\_\_\_ Relationship \_\_\_\_\_

**Student MAY NOT be released to:** \_\_\_\_\_

**Medical Information**

Family Physician: \_\_\_\_\_ Telephone # \_\_\_\_\_

Address: \_\_\_\_\_

Therapist/Outside Counselor \_\_\_\_\_ Telephone # \_\_\_\_\_

Address: \_\_\_\_\_

Medical Insurance: Yes \_\_\_ No \_\_\_ If yes, Provider \_\_\_\_\_

If no, NJ Family Care provides free or low cost health insurance for uninsured children and low income parents. For more information visit [www.njfamilycare.org](http://www.njfamilycare.org) to apply online.

Medical Problems/Condition \_\_\_\_\_

Allergies \_\_\_\_\_

Medications(s) \_\_\_\_\_

*As per New Jersey State Law, if you would like your child to be administered over the counter medication such as Tylenol, Tums, etc. at school, it is necessary for the school to have on file a written note from a physician. Without written authorization from a physician, we are unable to administer any over the counter medications to your child.*

*Do you authorize the school nurse to release information to pertinent school personnel on health concerns/medical needs that may affect your child's safety or performance in the school environment? Please check: Yes \_\_\_ No \_\_\_*

**Parent/Guardian Consent:** I grant permission for my child to attend any supervised, planned activity that requires leaving the school premises during the school year. **Please check: Yes \_\_\_ No \_\_\_** In the event it is required, I grant permission to Chancellor Academy to take my child to the appropriate facility in order that he/she may be provided with emergency medical attention. **Please check: Yes \_\_\_ No \_\_\_** I also grant permission for the Chancellor Academy staff to confer with my child's doctor and/or therapist. **Please check: Yes \_\_\_ No \_\_\_**

\_\_\_\_\_  
Signature of Parent/Guardian

/ \_\_\_\_\_ /  
Date

CASE MANAGER: \_\_\_\_\_

PHONE #: \_\_\_\_\_

email: \_\_\_\_\_