SUMMIT ACADEMY

Great minds don't think alike.

Student Name:_____

2024-2025

Primary Contact Phone:_____

Grade: _____ **DOB:**_____ **Gender**:_____

SSN (High School Students Only)_____

Primary Address:_____

City/State/Zip:_____

Student race/ethnicity (select all that apply):

☐ Asian or Pacific Islander ☐ Black or African American ☐ Hispanic or Latino

☐ Native American or Alaskan Native ☐ White or Caucasian ☐ A race/ethnicity not listed here

Mother's/Guardian's Information:

Name:_____

Address (if different):_____

City/State/Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Primary Email:_____

Father's/Guardian's Information:

Name:_____

Address (if different):_____

City/State/Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Primary Email:_____

Additional Permissions - For each individual you list, choose the appropriate permissions:

Name:_____ Phone:_____

☐ Emergency Contact ☐ Authorized Pick-up ☐ Educational records and communication

Name:_____ Phone:_____

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Name:_____ Phone:_____

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EMERGENCY/MEDICAL INFORMATION

Allergies: **Requires Emergency Medication:**

Food:_____ ☐ Yes ☐ No

Medication:_____ ☐ Yes ☐ No

Environmental:_____ ☐ Yes ☐ No

* If "yes" was selected, provide emergency medication protocol with the "Permission to Administer Medication" form to the Office Manager.

Medications:

Check any medications that you authorize Summit Academy personnel to administer:

☐ Tylenol ☐ Ibuprofen ☐ Benadryl ☐ Tums/Antacid ☐ NONE

List any medications (prescription or OTC) routinely taken at home and/or at school:

Name:_____ Dosage:_____

Time(s) take:_____ Take for:_____

Name:_____ Dosage:_____

Time(s) take:_____ Take for:_____

Name:_____ Dosage:_____

Time(s) take:_____ Take for:_____

Name:_____ Dosage:_____

Time(s) take:_____ Take for:_____

* If your child takes additional medications, please write or type a list and attach.

Diagnoses:

List all medical diagnoses:_____

_____

List any educational diagnoses: _____

_____

Does your student have a history of seizures? ☐ yes ☐ no

* If "yes" was selected, provide seizure protocol to the Office Manager.

In case of emergency:

Preferred hospital:_____

Pediatrician Name:_____

Practice Name:_____ Phone number:_____

List any additional information you feel would be relevant in an accident or emergency:

_____

_____

I _____, the parent(s)/guardian(s) of _____, do hereby consent that Summit Academy personnel may obtain emergency medical care for the above-named child at the expense fo the named parent/guardian, and release said personnel from any liability.

Parent/Guardian Signature_____ Date:

Family Information Update

Students Name:____**Grade:**__________________

<u>Parent Information:</u>

Mother's/Guardian's Name:____

Place of Employment: _________________________________Position/Job Title:____________________

Affiliations (civic organizations, board memberships, other):____

____

Father's/Guardian's Name:____

Place of Employment: _________________________________Position/Job Title:____________________

Affiliations (civic organizations, board memberships, other):____

____

Parents: If you would like your child's grandparents or other family members to receive newsletters, event invitations, and other mailings, please complete the information below. Include email addresses, if applicable

Name:____Relationship to student______________________

Address:____

Email Address:____

Name:____Relationship to student______________________

Address:____

Email Address:____

Name:____Relationship to student______________________

Address:____

Email Address:____

Name:____Relationship to student______________________

Address:____

Email Address:____

Name:____Relationship to student______________________

Address:____

Email Address:____