



**PARENT CONTACT INFORMATION CONTINUED, IF APPLICABLE**

Mother  Father  Guardian  Other \_\_\_\_\_  
Student Lives with Contact  yes  no

\_\_\_\_\_  
Last Name First Name  
\_\_\_\_\_  
Address City, State, Zip  
\_\_\_\_\_  
Primary Home Phone Primary Cell Phone Primary Work Phone  
\_\_\_\_\_  
Primary email Employer

XX

Mother  Father  Guardian  Other \_\_\_\_\_  
Student Lives with Contact  yes  no

\_\_\_\_\_  
Last Name First Name  
\_\_\_\_\_  
Address City, State, Zip  
\_\_\_\_\_  
Primary Home Phone Primary Cell Phone Primary Work Phone

**EMERGENCY CONTACT INFORMATION**

Relationship to student: \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name  
\_\_\_\_\_  
Primary Home Phone Primary Cell Phone Primary Work Phone  
\_\_\_\_\_  
XX

Relationship to student: \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name  
\_\_\_\_\_  
Primary Home Phone Primary Cell Phone Primary Work Phone

The above contacts have parent/guardian permission to pick up student in the event the parent/guardian is not available.

**Court Orders or Restraining Orders in effect that the school should be aware of:**  YES  NO  
Order Against: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

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

**NEWBURYPORT PUBLIC SCHOOLS ENROLLMENT FORM**  
**PLEASE COMPLETE AND REMIT TO SCHOOL'S MAIN OFFICE.**  
**YEARLY SIGNATURE REQUIRED ON PAGES 3 AND 4.**

Revised 4/14/2009

School \_\_\_\_\_ Teacher \_\_\_\_\_

**EMERGENCY CONTACTS**

Restraining Order \_\_\_\_\_ Order Against \_\_\_\_\_

Last Name	First Name	Home Phone	Work Phone	Ext	Cell Phone	Relationship to Student
Parent/Guard 1 _____						
Street Address _____		City _____		State _____		Zip _____
Parent/Guard 2 _____						
Street Address _____		City _____		State _____		Zip _____
Other Contact 1 _____						
Other Contact 2 _____						

**HEALTH CARE PROVIDERS**

Last Name	First Name	Phone No.	None	Health Insurance
Primary Doctor: _____	_____	_____	<input type="checkbox"/>	<input type="radio"/> Yes <input type="radio"/> No
Dentist: _____	_____	_____	<input type="checkbox"/>	Provider: _____
				Subscriber: _____
				No.: _____

**PARENTS MUST COMPLETE AND SIGN ANNUALLY**

Child Has Permission to Be Given: \_\_\_\_\_ Date \_\_\_\_\_

Tylenol:  Yes  No    Ibuprofen/Advil:  Yes  No    Cough Drops:  Yes  No    Potassium Iodide (KI)  Yes  No

Other: Name: \_\_\_\_\_

Takes Regular Medication  Yes  No    Name of Medication \_\_\_\_\_    Frequency \_\_\_\_\_

**Health/Medical Conditions/Allergies (check all that apply):**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> NONE                                     | <input type="checkbox"/> Contacts/Glasses/Visual | <input type="checkbox"/> Hemophilia                          | <input type="checkbox"/> Spina Bifida                   |
| <input type="checkbox"/> ADHD/ADD                                 | <input type="checkbox"/> Cystic Fibrosis         | <input type="checkbox"/> IEP/Sped                            | <input type="checkbox"/> Other Behavioral               |
| <input type="checkbox"/> Allergies Food                           | <input type="checkbox"/> Depression              | <input type="checkbox"/> Infectious Disease                  | <input type="checkbox"/> Other Blood Dyscrasias         |
| <input type="checkbox"/> Allergies Bee Stings                     | <input type="checkbox"/> Developmental Delay     | <input type="checkbox"/> Inflammatory Bowel Disease          | <input type="checkbox"/> Other                          |
| <input type="checkbox"/> Allergies Latex                          | <input type="checkbox"/> Diabetes Type I         | <input type="checkbox"/> Kidney Disease                      | <input type="checkbox"/> Other Physical Conditions      |
| <input type="checkbox"/> Allergies Other                          | <input type="checkbox"/> Diabetes Type II        | <input type="checkbox"/> Menstrual Issues                    | <input type="checkbox"/> Other Developmental Conditions |
| <input type="checkbox"/> Asthma/Respiratory                       | <input type="checkbox"/> Dizziness/Fainting      | <input type="checkbox"/> Migrane Headaches                   | <input type="checkbox"/> Other Behavioral Conditions    |
| <input type="checkbox"/> Autism                                   | <input type="checkbox"/> Ear Infection           | <input type="checkbox"/> Neuromuscular Degenerative Disorder | <input type="checkbox"/> Other Emotional Conditions     |
| <input type="checkbox"/> Autoimmune Disorders/Arthritis/Lupus etc | <input type="checkbox"/> Eating Disorder         | <input type="checkbox"/> Nose Bleed                          |   |
| <input type="checkbox"/> Cancer                                   | <input type="checkbox"/> Endocrine               | <input type="checkbox"/> Persistent Cough                    |   |
| <input type="checkbox"/> Cardiac Conditions/Heart Disease         | <input type="checkbox"/> Frequent Urination      | <input type="checkbox"/> Seizures/Neurological Disorder      |   |
| <input type="checkbox"/> Celiac Disease                           | <input type="checkbox"/> Gastrointestinal        | <input type="checkbox"/> Sickle Cell Trait                   |   |
| <input type="checkbox"/> Cerebral Palsey                          | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Skin Rashes                         |   |
| <input type="checkbox"/> Congenital Delay                         | <input type="checkbox"/> Hearing Problems        | <input type="checkbox"/> Speech                              |   |

**Describe conditions and medications:**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

My child has my permission to receive health/wellness and support services. This information will be shared with appropriate school personnel in order to meet your child's safety and health care needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.