

**GREENBURGH ELEVEN UNION FREE SCHOOL DISTRICT
P.O. BOX 501
DOBBS FERRY, NEW YORK 10522**

HIGHLY CONFIDENTIAL

DAY STUDENT DATA SHEET

NAME: _____ DOB: _____ OSIS: _____

HOME CSE: _____ CONTACT PERSON: _____ PHONE#: _____

PARENT/GUARDIAN _____ HOME PHONE#: _____

ADDRESS: _____ WORK PHONE#: _____

_____ CELL PHONE # _____

PARENT EMAIL ADDRESS _____

NEEDS INTERPRETER? YES: ___ NO: ___ LANGUAGE: _____

EMERGENCY CONTACT (PLEASE LIST AT LEAST 2)

1. _____ PHONE: _____

2. _____ PHONE: _____

EMERGENCY MEDICAL INFORMATION:

CHILD'S HOSP. /CLINIC _____

PHONE# _____ DOCTOR: _____

PHONE# _____ PSYCHIATRIST: _____

PHONE# _____ CLINIC NAME: _____

DENTIST: _____ COUNSELOR: _____

SPECIAL NEEDS (e.g. - MEDICATION, ALLERGIES TO FOOD, MEDICATION, INSECT STINGS/BITES,
ETC.?) _____

PAST OR CURRENT MEDICAL PROBLEMS _____

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I GIVE PERMISSION TO THE CHILDREN'S VILLAGE MEDICAL DEPARTMENT FOR AN ANNUAL
PHYSICAL EXAMINATION, ROUTINE, URGENT AND EMERGENCY MEDICAL TREATMENT AND
IMMUNIZATION IF A RECORD IS NOT PROVIDED.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

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TRANSPORTATION IS ARRANGED AND PROVIDED BY THE REFERRING DISTRICT.

BUS COMPANY AND ROUTE# _____