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

HIGHLY CONFIDENTIAL

RETURNING 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# ____