

Gasconade County R-1 Summer School Enrollment Information

*Please complete one form for each student and return to school promptly!

Grade Entering: _____

Which school did your child attend: _____

Name – Last First Middle Birth date Race Gender

Mailing Address Street, Route, Box Number City State Zip

Address of Residence (if different from the mailing address)

Best Contact Number Alternate Number County of Residence

Father: _____ Home Phone: _____

Father's Employer: _____ Work Phone: _____

Cell Phone: _____

Mother: _____ Home Phone: _____

Mother's Employer: _____ Work Phone: _____

Cell Phone: _____

Is there anyone who is NOT allowed to pick up your student? (please circle) YES NO

Name of person: _____

**If someone is not allowed to pick up your student, the school needs documentation, such as a court order, stating this.

Person(s) to contact in case of emergency if parents can not be reached:

Name Day Phone Relationship to Student

My student is enrolling in the following summer school course:

_____ Credit Recovery (date/time set individually)

_____ Driver's Education (Classroom Instruction 8:00-12:00 May 30, 31, June 1, 2, 5, 6, 7, 8)
(Driving: 6 hours and Observation: 12 hours will be scheduled individually)

Transportation: (Check ONE)

_____ I will provide transportation for my student.

_____ I would like bus transportation for my student. Available in the morning ONLY. Student must make arrangements for transportation at the end of class. (Student must be picked up at a location specified on the summer school bus schedule or along the route between the listed pick-up points. Please refer to bus schedule included in summer school packet for routes.)

PICK-UP point: _____

CUSTODIAL PARENT(S) SIGNATURE

Father Mother

Date Signed: _____ E-MAIL ADDRESS: _____

(OVER)

HEALTH EMERGENCY

Student _____ Grade Entering _____
Last Name First Name

Parent/Legal Guardian _____

Cell Phone: _____ Alternate Phone Number: _____

Emergency contact, if parent/guardian cannot be reached: _____ Phone: _____

Name of Insurance Company: _____

Family Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Does your student have any medical conditions or restrictions? YES NO
If yes, please explain

Does your student have any known allergies? YES NO If yes, list: _____

Is your student on ANY medications? YES NO If yes, list: _____

If yes, does daily medication need to be given during summer school hours? YES NO

Does your student have any vision problems? YES NO

Does your student have any hearing problems? YES NO

****If medications of any kind are given at school, a PHYSICIAN AUTHORIZATION FORM must be signed and renewed for each school year!**

In case of accident or serious illness, I request school personnel to contact me, alternate authorized persons, or the named physician. If it is impossible to contact me, authorized persons, or the physician, the school personnel may make emergency arrangements as necessary for my student.

Parent/Guardian Signature: _____ Date: _____

Please complete and return to school promptly.