



CLARENDON HALL STUDENT INFORMATION

* NEW FORM REQUIRED EACH SCHOOL YEAR. *DATE COMPLETED: _____

Student's Full Name _____

Date & Place of Birth _____ / _____ Student's Social Security # _____ - _____ - _____
(COPY OF BIRTH CERTIFICATE REQUIRED ON NEW STUDENTS)

Physical Address _____ Mailing Address _____

City _____ State _____ Zip _____ E-Mail Address _____

Father's Name _____ Home Phone _____ Cell Phone _____ Other Phone _____

Business Name & Occupation _____ Work Phone _____ Exten# _____

Mother's Name _____ Home Phone _____ Cell Phone _____ Other Phone _____

Business Name & Occupation _____ Work Phone _____ Exten# _____

Grandparent's Name _____ Phone _____

Grandparent's Address: _____

Other Parent Name & Address _____
(If both parents do not live in the home, please list second parent name & address here.)

****Name & Telephone Number of Nearest Neighbor or Relative who may be contacted in emergencies if parents listed above cannot be reached. Please list at least one local name & phone number. (Please specify if neighbor, relative, grandparent, etc.)**

Do both parents live in the home? _____ Parent's Church Affiliation _____

Name and Ages of Siblings _____

Name & Address of Last School Attended _____

***New applicants must submit copy of last report card and copy of last Standardized Tests or bring to interview. New applicants or students entering Kindergarten must submit a copy of Birth Certificate, copy of Social Security card, and a current SC DHEC certificate of immunization. Students transferring from an out of state school will need to transfer their shot record to a South Carolina form at a local county health department.**

Date and place of Last Eye Exam _____ Does Child Wear Glasses? _____

***Does the child have a history of convulsions, asthma, or other conditions, which may affect his work at school?**

Child's Physician _____ Phone _____

It is the policy of this school to notify the parent when a student becomes ill or is hurt. However, in cases of emergency or when a parent cannot be contacted, it may be necessary that a student be carried immediately to a doctor & this information must be in the school records.

Are there any medications or treatments to which the child is allergic? _____

List any medications child is on or may be given for allergic reaction. _____

List any medication child takes on a daily basis. _____

Is child allowed to take Tylenol? _____ If NO, PLEASE SIGN HERE _____

Is child allowed to take Ibuprofen? _____ If NO, PLEASE SIGN HERE _____

Is child allowed to take Pepto Bismol? _____ If NO, PLEASE SIGN HERE _____

Specific dosages: (Example: 2 adult, 1 child, etc.) _____

(If no dosage is specified, medication will be administered as recommended dosage for age/weight on medicine label.)

***ALL PRESCRIPTION DRUGS, WHICH A CHILD MUST TAKE DURING SCHOOL HOURS, MUST BE KEPT IN THE SCHOOL OFFICE. PLEASE CONTACT THE OFFICE STAFF FOR PROCEDURES FOR PRESCRIPTION DRUGS.**

****IF YOUR CHILD HAS A MEDICAL CONDITION OR CHRONIC PROBLEM, NON-PRESCRIPTION DRUGS MAY BE SENT TO THE OFFICE WITH THEIR NAME TO BE DISPENSED DURING THE SCHOOL DAY. (THIS INCLUDES TYLENOL, IBUPROFEN, COUGH DROPS, COLD MEDICATIONS, SINUS OR ALLERGY MEDICATIONS, PEPTO BISMOL, ETC.)**

ABSOLUTELY NO MEDICATION MAY BE KEPT IN THE STUDENTS POSSESSION AT ANY TIME AT SCHOOL.

An exception may be made for inhalers with prior administration approval.



CLARENDON HALL

STUDENT MEDICAL/ EMERGENCY INFORMATION
THIS MEDICAL INFO SHEET MUST BE COMPLETED AND
RETURNED WITH TUITION CONTRACT

Student's Name: _____ Grade: _____ Homeroom Teacher _____

Date of Birth: _____ SS# _____ - _____ - _____

Mother's Name: _____

Home Phone _____ Work Phone: _____ Pager/Cell Phone _____

Father's Name: _____

Home Phone _____ Work Phone: _____ Pager/Cell Phone _____

Grandparent's Name: _____

Home Phone _____ Work Phone: _____ Pager/Cell Phone _____

Emergency Contact names and phone numbers: _____

INSURANCE VERIFICATION

Insurance Provider: _____ Policy # _____

Family Physician: _____ Office Phone: _____

EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT

I, _____, as the parent or guardian of, _____, recognize that as a result of participation in student activities, medical treatment on an emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance.

Please make the following notations on my son or daughter's records: Medical Allergies:

Medications for long-term illness (list illness and medication): _____

Relevant medical information (e.g., contact lens wearer, history of family diabetes, epilepsy, heart murmur, etc.): _____

It is the parent's responsibility to keep all insurance and medical/emergency information current throughout the entire school year.

_____ Date

_____ Signature of Parent or Legal Guardian