PO Box 12
Glenwood, WA 98619

GLENWOOD SCHOOL DISTRICT

Phone: 509-364-3438
Fax: 509-364-3689

STUDENT INFORMATION

STUDENT NAME: Legal Name: First, Middle, Last			TODAYS DATE:
BIRTHDATE:	GENDER: Male Female	BIRTHPLACE: City State	GRADE LEVEL

PARENT CONTACT INFORMATION

FATHER'S NAME:	MOTHER'S NAME:	
MAILING ADDRESS:		
PHYSICAL ADDRESS:		
HOME PHONE:	WORK PHONE: Father: Mother:	CELL PHONE: Father: Mother:
MOTHER'S EMAIL ADDRESS:		
FATHER'S EMAIL ADDRESS:		

EMERGENCY INFORMATION

Who can we contact and/or send your child home with in case of an emergency if you are not available?

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

If the above cannot be contacted, can we contact your family physician? _____ YES _____ NO

CLINIC & FAMILY PHYSICIAN NAME: PHONE:

AUTHORIZATION FOR ANOTHER TO CONSENT TO TREATMENT OF A MINOR

I understand that if either parent/guardian or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize the Glenwood School staff to request emergency medical services (911). I understand I may be responsible for the payment of any medical services if needed. This authorization will begin today and will expire when the child withdrawls from the District. ____ YES ____ NO

If you chose no please list an alternative person:

NAME: ADDRESS: PHONE NUMBERS: