



Office Use Only:

Year: 19/20

Grade: \_\_\_\_\_

Room: \_\_\_\_\_

### ELEMENTARY PSR INFORMATION SHEET

STUDENT'S NAME: \_\_\_\_\_  
First Last

DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Number & Road City Zip

PHONE: HOME \_\_\_\_\_ PARENT'S CELL \_\_\_\_\_

PARENT'S E-MAIL ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_  
First Last Mother's Maiden Name

FATHER'S NAME: \_\_\_\_\_  
First Last

CHARACTER OF HOME: (Please Circle)

- A. Two Parent Family
- B. Single Parent and child is living with...
  - a. Father
  - b. Stepfather
  - c. Mother
  - d. Stepmother
- C. Court Ward/Foster Child
- D. Father is deceased
- E. Mother is deceased

Guardian (If applicable) \_\_\_\_\_ Religion \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Are Parents Divorced? \_\_\_\_\_ Yes \_\_\_\_\_ No

If parents are divorced, are there any custody restrictions we need to be aware of?

Please note:

\_\_\_\_\_  
\_\_\_\_\_

PUBLIC SCHOOL CHILD IS CURRENTLY ATTENDING: \_\_\_\_\_

May we take pictures/video of your child for PSR purposes? \_\_\_\_\_ Yes \_\_\_\_\_ No

LEARNING DISABILITIES/SPECIAL NEEDS:

In order to provide the best Christian learning environment possible for your child, please list below any special learning disabilities or physical handicaps that your child may have. This information will be available only to the administration and the teacher. If you would like to discuss this in more detail, please call Ms. Lori Mascia at 440-449-4242 Ext. 119.

\_\_\_\_\_  
\_\_\_\_\_

Parent/legal Guardian Signature \_\_\_\_\_

**PART I OR II MUST BE COMPLETED**

**PART I (TO GRANT CONSENT)**

In the event reasonable attempts to contact me at: ( ) \_\_\_\_\_ or \_\_\_\_\_  
(phone) (other parent)  
at ( ) \_\_\_\_\_ have been unsuccessful, I hereby give my consent for: (1) The administration  
of any treatment deemed necessary by Dr. \_\_\_\_\_, or Dr. \_\_\_\_\_ or in the  
(dentist) (physician)  
event the designated preferred practitioner is not available, by another licensed physician or dentist; and  
(2) The transfer of the child to: \_\_\_\_\_ hospital or any hospital reasonably  
accessible. This authorization does not cover major surgery unless the medical opinions of two other  
licensed physicians or dentist, concurring in the necessity for such surgery, are obtained before surgery  
is performed.

Date: \_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_

**PART II (REFUSAL TO CONSENT)**

**DO NOT COMPLETE PART II IF YOU COMPLETED PART I**

I **do not** give my consent for emergency medical treatment of my child. In the event of illness or  
injury requiring emergency treatment, I wish the school authorities to take no action or to:

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_

**It is also necessary for us to have the doctor's name and phone number.  
Please include this information below:**

Doctor: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

RE: Privacy Act. It is understood that no student information will be given out without parental consent.  
However, we wish to inform you that your name and home phone number will be given to selected adults who  
will keep the information confidential and will use it only to inform you of emergency situations. If you have  
any problem with this policy, please call me at (440) 449-4242 ext. 119.

I have read the above statement regarding the Privacy of Student Information.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_