



CENTRAL CITY PUBLIC SCHOOLS
1711 15TH AVENUE
P O BOX 57
CENTRAL CITY, NEBRASKA 68826-0057
308-946-3055
CANDACE CONRADT, SUPERINTENDENT

Home of the Bison

ANNUAL STUDENT UPDATE REQUEST

(THIS FORM IS REQUIRED FOR ALL STUDENTS IN THE DISTRICT)

SCHOOL YEAR _____ FULL NAME OF STUDENT _____ GRADE _____

PRIMARY HOUSEHOLD INFORMATION: Name(s) of person(s) WITH WHOM STUDENT IS LIVING. (Check one)

Use BACK OF PAGE to supply information concerning other parent(s) and/or guardian(s) _____ Both Parents _____ Mother Only _____ Father Only			
_____ Self _____ Agency(Foster) _____ Guardian Mother/Stepfather _____ Father/Stepmother _____ Stepfather/Stepmother _____ Other			
Title (circle): Mr. Mrs. Miss Ms. Last Name	First Name	Work Place & City	Ext. Business Phone
			Home &/or Cell# email address
Title (circle): Mr. Mrs. Miss Ms. Last Name	First Name	Work Place & City	Business Phone Ext.
			Home &/or Cell# email address
Parent/Guardian Street Address		City	Zip County
Parent/Guardian Mailing Address (if different than above)		City	Zip County

Ethnic Category (Check One)

Asian Black or African American American Indian or Alaska Native Native Hawaiian or Other Pacific Islander
 White Hispanic or Latino Two or More Races Other

EMERGENCY INFORMATION: List two local persons (other than yourself) usually available during the school day who have agreed to care for and provide transportation for your student if he/she becomes ill or injured and you cannot be reached. We attempt to contact parents first.

Last Name	First Name	Relationship to Student	Daytime Phone <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> W Ext.
			()
Last Name	First Name	Relationship to Student	Daytime Phone <input type="checkbox"/> H <input type="checkbox"/> C <input type="checkbox"/> W Ext.
			()

Enter the name of your family physician who may be contacted by school staff when parent cannot be reached and medical assistance is indicated. If you have no family doctor, you can state any local physician.

Family Doctor	Phone Number	Ext.
Family Dentist	Phone Number	Ext.

2ND MAILING INFORMATION, if any: Name of Parent(s) and/or Guardian(s) OTHER than those listed under Primary Household Information.

Title (circle): Mr. Mrs. Miss Ms. Last Name	First Name	Work Place & City	Ext. Business Phone
			Home &/or Cell#
			email address

PARENT NOTIFICATION: According to the Family Educational Rights & Privacy Act (FERPA), both custodial and non-custodial parents have the same access to the child and to educational records concerning their child, UNLESS the school has been provided with a court order or other legally binding document relating to such matters as divorce, separation, or custody that specifically revokes those rights. (34 CFR99.4) The school MUST have a copy of the most recent court order on file; otherwise either parent has access to school records and may also check the child out of school (with proper identification). Your signature and date on this application acknowledges only that you have read this notification.

HEALTH INFORMATION UPDATE

Last Physical Exam Date: _____ Last Dental Exam Date: _____ Vision Specialist: _____ Last Vision Exam Date: _____

Does your student have any hearing concerns: _____ No _____ Yes, please explain: _____

Has your student ever had ear tubes? _____ No _____ Yes (List year of Insertion) _____

Does your student have any vision concerns? _____ No _____ Yes, please explain: _____

Has your student ever worn contacts or glasses? _____ No _____ Yes, please explain: _____

Allergies: _____ No _____ Yes (Please list) _____

NOTE: ANY life threatening bee sting allergies or food allergies require a written note, from your student's physician, with specific instructions for school personnel.

Does your student have any of the following: (Circle Y for Yes and N for No)

Asthma	Yes	No	Emotional Concerns	Yes	No	Hepatitis	Yes	No
ADHD/ADD	Yes	No	Epilepsy/Seizure	Yes	No	Orthopedic Concerns	Yes	No
Cerebral Palsy	Yes	No	Heart Condition	Yes	No	Other	Yes	No
Diabetes	Yes	No						

If yes, please provide additional information about the current condition and management below.)

Has your student had a recent injury or illness that might limit them in school? _____ No _____ Yes, please explain: _____

Recent immunizations? _____ No _____ Yes, please list: _____

PLEASE LIST ANY MEDICATION YOUR STUDENT WILL BE TAKING:

AT SCHOOL: _____

AT HOME: _____

NOTE: YOU ARE REQUIRED TO COMPLETE A MEDICATION PERMISSION FORM FOR YOUR STUDENT TO TAKE ANY MEDICATION AT SCHOOL. THIS WILL BE COMPLETED FOR ALL NEW MEDICATIONS AND EACH TIME THERE IS A CHANGE IN DOSAGE, TIME, OR ADMINISTRATION. MEDICATION MUST BE BROUGHT IN THE ORIGINAL LABELED CONTAINER.

May the School Nurse or Her Designee Provide Acetaminophen to your Student?	_____ NO _____ YES
May the School Nurse or Her Designee Provide Ibuprofen to your Student?	_____ NO _____ YES

NOTE: Your signature below does the following:

- Gives the School Nurse or her designee permission to release health information to school personnel if needed for education and/or safety reasons.
- Gives School Personnel permission to follow the attack on Asthma Protocol in the Central City Public Schools Student Handbook.

SIGNATURE OF PARENT OR GUARDIAN: _____ **DATE:** _____