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

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/WHERE.** (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
Where does the student stay at night? _____ In a home you rent or own ____ Other_________________________________
_____ Temporarily with another family in house/mobile home or apartment _____ In a hotel or motel

Title (circle): Mr. Mrs. Miss Ms. Last Name	First Name	Work Place & City	Ext.Business Phone ( )	
			Cellular/Pager: ( )	email address
Title (circle): Mr. Mrs. Miss Ms. Last Name	First Name	Work Place & City	( ) Business Phone	Ext.
			Cellular/Pager: ( )	email address

Parent/Guardian Street Address	City	Zip	County
Parent/Guardian Mailing Address (if different than above)	City	Zip	County

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 ☐ H ☐ C ☐ W ( )	Ext.
Last Name	First Name	Relationship to Student	Daytime Phone ☐ H ☐ C ☐ 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.

We occasionally receive requests from news media to take photographs or videotape in the classroom.
Please indicate below whether or not you agree to allow your child to appear in media products. ____Yes or ____ No

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 ( )	
			Cellular/Pager: ( )	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	Y / N	Emotional Concerns	Y / N	Hepatitis	Y / N
ADHD/ADD	Y / N	Epilepsy/Seizure	Y / N	Orthopedic Concerns	Y / N
Cerebral Palsy	Y / N	Heart Conditions	Y / N	Other	Y / N
Diabetes	Y / N				

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: ________________________