Student Contact Information Update Form

Student ID: Grade: Homeroom: Homeroom Teacher:

Student Legal Name as listed on birth certificate

*First Name: First Name: _____

*Middle Name: Middle Name: _____

*Last Name: Last Name: _____

Home Address

*Street & Apt. : Street & Apt. : _____

*City, State, Zip: City, State, Zip: _____

*Home Phone: Home Phone: (_____) _____-_____

*Primary Contact Phone: Primary Contact Phone: (_____) _____-_____

Mailing Address [ ] Same as Home Address

*Street & Apt. : Street & Apt. : _____

*City, State, Zip: City, State, Zip: _____

Contact # 1 (must reside with student)

*Contact Type: Contact Type: [ ] Legal Guardian [ ] Emergency Contact [ ] Other

*Relationship to Student: Relationship to Student: _____

*First Name: First Name: _____

Middle Name: Middle Name: _____

*Last Name: Last Name: _____

Cell Phone: Cell Phone: (_____) _____-_____

Employer Name: Employer Name: _____

Work Phone: Work Phone: (_____) _____-_____

Education Level: Education Level: [ ] High School and up [ ] Less than High School

E-Mail Address: E-Mail Address: _____

Language for Communications: Language for Communications: _____

Contact # 2

*Contact Type: Contact Type: [ ] Legal Guardian [ ] Emergency Contact [ ] Other

*Relationship to Student: Relationship to Student: _____

*First Name: First Name: _____

Middle Name: Middle Name: _____

*Last Name: Last Name: _____

*Street & Apt. : Street & Apt. : _____

*City, State, Zip: City, State, Zip: _____

Home Phone: Home Phone: (_____) _____-_____

Cell Phone: Cell Phone: (_____) _____-_____

Employer Name: Employer Name: _____

Work Phone: Work Phone: (_____) _____-_____

Education Level: Education Level: [ ] High School and up [ ] Less than High School

E-Mail Address: E-Mail Address: _____

Language for Communications: Language for Communications: _____

Contact # 3

*Contact Type:	Contact Type: [ ] Legal Guardian [ ] Emergency Contact [ ] Other
*Relationship to Student:	Relationship to Student: _____
*First Name:	First Name: _____
Middle Name:	Middle Name: _____
*Last Name:	Last Name: _____
*Street & Apt. :	Street & Apt. : _____
*City, State, Zip:	City, State, Zip: _____
Home Phone:	Home Phone: (_____) _____-_____
Cell Phone:	Cell Phone: (_____) _____-_____
Employer Name:	Employer Name: _____
Work Phone:	Work Phone: (_____) _____-_____
Education Level:	Education Level: [ ] High School and up [ ] Less than High School
E-Mail Address:	E-Mail Address: _____
Language for Communications:	Language for Communications: _____

Contact # 4

*Contact Type:	Contact Type: [ ] Legal Guardian [ ] Emergency Contact [ ] Other
*Relationship to Student:	Relationship to Student: _____
*First Name:	First Name: _____
Middle Name:	Middle Name: _____
*Last Name:	Last Name: _____
*Street & Apt. :	Street & Apt. : _____
*City, State, Zip:	City, State, Zip: _____
Home Phone:	Home Phone: (_____) _____-_____
Cell Phone:	Cell Phone: (_____) _____-_____
Employer Name:	Employer Name: _____
Work Phone:	Work Phone: (_____) _____-_____
Education Level:	Education Level: [ ] High School and up [ ] Less than High School
E-Mail Address:	E-Mail Address: _____
Language for Communications:	Language for Communications: _____

* Indicates a required field (also, all contacts must have at least one phone number)

Print Name: _____

Sign: _____ Date: _____/_____/_____

Plainfield Community Consolidated School District 202

We prepare learners for the future.

Administration Center
15732 Howard Street
Plainfield, IL 60544

(815) 577-4000 – telephone
Web: www.psd202.org

Student Health History

Student Name: _____ Grade: _____ School: _____

Sex: ☐ Male ☐ Female Birth Date: _____ Phone Number: _____

Doctor's Name: _____

(if you indicate YES for any category, please explain)

#	Concern	Yes or No	Explanation & Comments
1	Allergies	☐ Yes ☐ No	
	*Uses EpiPen	☐ Yes ☐ No	
2	Asthma	☐ Yes ☐ No	
	*Uses Inhaler	☐ Yes ☐ No	☐ Rarely ☐ Once daily ☐ More than once daily ☐ For Sports
	*Uses Inhaler at School	☐ Yes ☐ No	
3	Blood Disorders	☐ Yes ☐ No	
4	Daily Medications	☐ Yes ☐ No	
	*Names of Medication(s)	At home	
	School Medications REQUIRE Medical Authorization Form	At school	
5	Diabetes	☐ Yes ☐ No	
6	Ear / Hearing Problems	☐ Yes ☐ No	
7	Glasses / Contacts	☐ Yes ☐ No	Last eye exam:
8	Eye / Vision Problems	☐ Yes ☐ No	
9	Heart Problems	☐ Yes ☐ No	
10	Hospitalizations	☐ Yes ☐ No	Age:
11	Mental Health Concerns	☐ Yes ☐ No	
12	Neurological Problems	☐ Yes ☐ No	
13	Physical Restrictions	☐ Yes ☐ No	
14	Seizures	☐ Yes ☐ No	
15	Serious Injuries	☐ Yes ☐ No	Age:
16	Surgery	☐ Yes ☐ No	Age:
17	Other	☐ Yes ☐ No	

I release this information to be shared with appropriate school and emergency personnel for health and educational purposes.

_____ _____

Parent / Guardian Signature Date