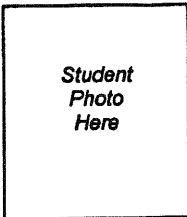


METROPOLITAN SCHOOL DISTRICT OF MT. VERNON  
ENROLLMENT & MEDICAL INFORMATION  
(Please print)



School Use Only: ID# \_\_\_\_\_ STN# \_\_\_\_\_ Enroll Date \_\_\_\_\_ Yr of Grad \_\_\_\_\_

School \_\_\_\_\_ Bus # AM \_\_\_\_\_ Bus # PM \_\_\_\_\_ Grade \_\_\_\_\_  
Student Name (Last, First, Middle) \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Gender \_\_\_ Male \_\_\_ Female Date of Birth \_\_\_\_\_ Birthplace \_\_\_\_\_  
Ethnicity Is student Hispanic or Latino? \_\_\_ Yes \_\_\_ No  
Race (check one or more) \_\_\_ American Indian/Alaskan \_\_\_ Asian \_\_\_ Black/African American \_\_\_ Hawaiian/Pacific Islander \_\_\_ White

1st Parent Name \_\_\_\_\_ Relationship \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

2nd Parent Name \_\_\_\_\_ Relationship \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
With whom does your student live? \_\_\_ Mother \_\_\_ Father \_\_\_ Both \_\_\_ Guardian \_\_\_ Other \_\_\_\_\_

Other Emergency Contact if unable to contact parent/guardian above, please contact:  
1. \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
2. \_\_\_\_\_ Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

School Last Attended Name \_\_\_\_\_ Grade \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Other Family at Home Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_

Medical  
Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Hospital Preference \_\_\_\_\_ School Insurance \_\_\_ Yes \_\_\_ No Other Insurance \_\_\_\_\_  
Student's Medical Problems (i.e. allergies, medications) \_\_\_\_\_

**Authorization and Permission**  
I hereby give my permission, for the safety of my child, to share the above medical information with the appropriate MSD of Mt. Vernon employees and emergency medical personnel as necessary. I also give my permission and authorize school officials to administer first aid in case of illness or accident at school or at school-sponsored activities.

I further give permission and authorize the MSD of Mt. Vernon, and any employees thereof, to obtain any medical services, including but not limited to calling an ambulance and/or x-ray examination, anesthetic, surgical treatment, or any hospital service, for the above named student in the event said student suffers any illness or accident.

This medical consent is given in advance of treatment to encourage and authorize the school and employees and/or physicians to exercise their judgment in the best interest of my child. I also understand that I will assume full financial responsibility for necessary expenses as may be incurred in the foregoing.

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