STAR CAST EXPLORERS
STUDENT INFORMATION FORM

****Please fill out this form on both sides completely and return it to the STAR CAST EXPLORERS office as soon as possible.**

Homeroom Teacher_____ **# of Days per Week Attending Program**____

Homeroom _____ Grade _____

Student Information:

Name _____
Last Name **First Name** **Middle**

Street Address_____

City/Town _____ **Zip Code** _____

Telephone Number _____ **Cell Phone** _____
Area Code **Number** **Area Code** **Number**

Date of Birth _____ **Please Circle:** **Male** **Female**
Month **Day** **Year**

My child is: **oldest** **youngest** **only child** **Number of Siblings:** **Younger**____ **Oldest**____

School District for Transportation and Bus # (if will sometimes take the bus home):_____

** **My Child:** **(Circle One)** **May Not be Photographed** **May be Photographed**
Parent /Guardian Signature_____

Parent / Guardian Information:

Mother: **Mrs.** **Ms.** **Miss** **Marital Status:** **Married** **Remarried** **Single** **Divorced**
(Please circle one) **Separated** **Deceased** **(Please circle one)**

Name _____
Last Name **First Name**

Street Address_____

City/Town _____ **Zip Code** _____

Home Telephone Number _____ **Cell Phone** _____
Area Code **Number** **Area Code** **Number**

Occupation_____ **Employer**_____**Department** _____

Employer's Address _____**Telephone**_____**Extension**_____

Father: **Marital Status:** **Married** **Remarried** **Single** **Divorced**
Separated **Deceased** **(Please circle one)**

Name _____
Last Name **First Name**

Street Address_____

City/Town _____ **Zip Code** _____

Telephone Number _____ **Cell Phone** _____
Area Code **Number** **Area Code** **Number**

Occupation_____**Employer**_____**Department** _____

Employer's Address _____**Telephone**_____**Extension**_____

*****E-MAIL ADDRESS:** **MOTHER** _____

FATHER_____

PLEASE COMPLETE THIS SIDE OF THE FORM COMPLETELY
****ONLY TO BE FILLED OUT BY PARENT OR GUARDIAN****

MEDICAL HISTORY

Student's Name_____ **Grade** _____ **Homeroom**_____

Date of Birth _____

Please check off any or all of the following that applies to your child:

Diabetes ___ **If yes, indicate type of allegies and medication taken** _____

_____

Allergies___ **If yes, indicate type of allegies and medication taken** _____

_____

Chronic Conditions (Asthma, etc.) ____ **If yes indicate condition**_____

Medications taken_____

Please describe and list below any additional conditions, medications, etc. _____

_____

_____

Is your child covered by health insurance_____

What coverage and carrier_____

EMERGENCY CONTACT

WHEN PARENT/GUARDIAN CANNOT BE CONTACTED

Person to contact if cannot reach parent first when child is ill or in an emergency.

Name _____ **Relationship** _____
Last **First**

Address _____
Number **Street** **City/Town** **Zip**

Telephone: Home_____ **Work**_____ **Cell Phone**_____

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Parent/Guardian Signature _____

PHYSICIAN INFORMATION

Physician 's Name_____

Telephone Number _____

Address_____