

# Trinity Catholic High School Student Information Form 2009-2010

**Student's Name** \_\_\_\_\_ **Grade** \_\_\_\_\_

Student Home Address \_\_\_\_\_

Student Email Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Student Cell Phone: \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ Living  Deceased

Mother's Home Address: \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Position \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Mother's Email \_\_\_\_\_

**Father's Name** \_\_\_\_\_ Living  Deceased

Father's Home Address: \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Position \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Father's Email \_\_\_\_\_

**Parent's Marital Status**     Married     Separated     Divorced

If the student does not reside with both parents, who is the designated recipient of school information

\_\_\_\_\_

**Non-Parental Emergency Contact** \_\_\_\_\_

Relationship to student \_\_\_\_\_ Telephone \_\_\_\_\_

**Additional Information**

Student's Ethnicity     Asian     Black     Latino     White     Multi-racial

Primary language spoken at home: \_\_\_\_\_

Religious Affiliation \_\_\_\_\_ Place of Worship \_\_\_\_\_

## Student Health Information

**Student Name:** \_\_\_\_\_

**Medical Conditions:**

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**Prescriptions:**

Medication

Ordering Physician

Telephone

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**Allergies (to food, insects, medicine)**

Specific Allergy

Recommended Treatment

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**Medical Care Information:**

PHYSICIAN/CLINIC Name \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

DENTIST Name \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

**Health Insurance Information:**

Insurance Provider \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

I give TCHS permission to use photographs of my child in school materials and/or to release information about achievements to local newspapers.     yes     no

**In the event of an emergency, the faculty and staff of Trinity Catholic High School have my permission to seek emergency care for my son/daughter at the nearest appropriate facility.**

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_