Notre Dame Summer Academy Student Information Form

Student Registration will not be finalized until we have received a completed copy of this form.

Email to: wmontgomery@ndhsb.org
Fax to: Winifred Montgomery; (650) 595-4536

Mail to: Winifred Montgomery
Notre Dame High School
1540 Ralston Avenue
Belmont, CA 94002

IMPORTANT!

Please check below to indicate the program in which this student is enrolling in Summer 2010:

❑ **High School Preparatory** ❑ **Middle School Academy**

Student's Information	**Name of Student** (Last, First, Middle)	**Grade student will enter in Fall of 2010**
		Date of Birth
	Student Address (Including Street, Apt.#, City, State, Zip)	**Family Home Phone** (Including area code)
		Parent E-mail
	Student Lives with (check all that apply) ❑Mother ❑Father ❑Guardian(s) (specify)________________	
Father's or Legal Guardian's Information	**Father's or Legal Guardian's Name** (Last, First)	**Home Phone** (If different from Student's)
	Home Address (If different from Student's)	**Work Information** (Name of Company, Street, City, State, and Zip)
	Work Telephone (Including area code) ( )	**Cell Phone** (Including area code) ( )
	Work E-Mail	
Mother's or Legal Guardian's Information	**Mother's or Legal Guardian's Name** (Last, First)	**Home Phone** (If different from Student's)
	Home Address (If different from Student's)	**Work Information** (Name of Company, Street, City, State, and Zip)
	Work Telephone (Including area code) ( )	**Cell Phone** (Including area code) ( )
	Work E-Mail	

Student Name:____

Emergency Contact 1: (Last Name, First Name)	**Home Phone** **Work Phone** **CellPhone**
Emergency Contact 2: (Last Name, First Name)	**Home Phone** **Work Phone** **CellPhone**

STUDENT'S MEDICAL INFORMATION A parent note is required for any and all medications taken and not included on this info. form.

Medical Condition for which medicine is being taken: **1. Medicine name:** **Dosage:** **Frequency:**
Medical Condition for which medicine is being taken: **2. Medicine name:** **Dosage:** **Frequency:**
Other medicine(s) to be administered for minor injuries, headaches, cramps, etc.: **3. TYLENOL (dosage___/frequency___) 4. IBUPROFEN (dosage___/frequency___) 5.COUGH DROPS (dosage___/frequency___)**

I grant my child permission to take the medications listed above in #1,2,3,4,5 (Please sign below to authorize the administration of medication by school personnel)
Signature Required:

Medications being taken by the Student	**Medicines to be self-administered by Student**
Primary Care Physician (Name, Address, City)	**Primary Care Physician** (Telephone) ( )
Dentist (Name, Address, City)	**Dentist** (Telephone) ( )
Allergies (e.g. foods, hay fever etc.)	**Allergies to Medications (please include what the reaction is** (hives, stops breathing etc.)

In the event the school is not able to reach the above named persons, I give my permission to the administration, instructor, or coach to contact an ambulance. ❑ **Yes** ❑ **No**

Signature	**Relationship**	**Date**

Please note: We often use photos of happy students in our marketing materials. Please inform us in writing if you do not want your daughter's image used.

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