Scholars™

EDUCATION CENTRE

Information Shee

Student Programmi

Today's Date:

Student Information

Students Name: | Date of Birth: | Grade: | Age:

Address: STREET | TOWN / CITY

Parent/Guardian Names:

Phone: HOME | MOBILE | WORK

E-mail:

Siblings: | Ages:

Medical Information

Student's Health Card #: | Family Doctor: | Phone:

Does your child wear eye glasses? ☐YES ☐NO — If yes, please explain: ____________

Eye defects? ☐YES ☐NO — If yes, please explain: ____________

Hearing Problem? ☐YES ☐NO — If yes, please explain: ____________

Speech problems? ☐YES ☐NO — If yes, please explain: ____________

Serious early childhood problems? ☐YES ☐NO — If yes, please explain: ____________

Current health problems? (ie. allergies) ☐YES ☐NO — If yes, please explain: ____________

On any medication? ☐YES ☐NO — If yes, please explain: ____________

Psychological or neurological evaluation? ☐YES ☐NO — When? ____________ By whom? ____________

Ever experienced unconsciousness? ☐YES ☐NO — When? ____________ For how long? ____________

Emergency Contacts

Permission is granted to the staff of Scholars Education Centre to secure appropriate medical services for ______________________________ should it be impossible to contact either emergency contact.

Emergency Contact #1 :	Emergency Contact #2 :
Relationship to child:	Relationship to child:
Phone:	Phone:

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Parent/Guardian Signature   Date