Gateway Regional High School District
Academic Support Services
Summer Program Application (June 30, 2009 through July 23, 2009)

Student Name:______________________________ Middle Name:_____________

Parent(s) Name: ____

Mailing Address: ____

____

Street Address: ____

____

Town: ____

Zip Code: ____

Phone Number: ____

E-Mail address: ____

Please check present grade:

Grade: _____ 5 _____ 6 ______ 7 ______ 8 ______ 9 ______ 10 ______ 11

Be sure to complete the attached emergency form and return with this application.

Parent/Guardian Name (please print) ______________________________________

Parent/Guardian Signature ____

Date: ______________________

Gateway Regional School District
Health Services

Student's Name________________________ Date of Birth______ Grade_____

Address____ Telephone__________

City & State____

Father's Name____

Mother's Name____

Medical Insurance____

Medical Insurance Certificate #_______________________________________

Student's Health Care
Provider__________________________ Telephone_____________________

Provider's Address____

Student's
Dentist____________________ Telephone__________________________

Address____

List any health issues your child has___________________________________

____

List any known allergies that your child has_____________________________

List medications (and dosage) that your child takes______________________

____

I give the school nurse permission to share medical information pertaining to my child to

appropriate school staff.____
Parent/guardian signature

Gateway Regional School District Summer 2009

EMERGENCY CARD

Grade: __________

Pupil's Name: ______________________ Birth Date: ______________

Residential Address: ______________________ School: ______________

Mailing Address: ______________________ Phone: ______________

In case of emergency, illness, or accident to the child named above, the school is authorized to proceed as indicated. State preference of action below: 1, 2, 3, 4, 5.

( ) Contact father at: ______________________ ______________
firm name and address phone

( ) Contact mother at: ______________________ ______________
firm name and address phone

( ) Other Responsible Adult: 1. ______________________ ______________
name and address phone

( ) At least two in town contact: 2. ______________________ ______________
name and address phone

3. ______________________ ______________
name and address phone

( ) Take child to Emergency Hospital

It is agreed that your signature authorizes the school to take emergency medical action if the above conditions are not available, at your own expense.

______________	______________	______________
Father's Name	Mother's Name	Guardian's Name
Signature	Signature	Signature
Date: ______________		Please complete revers