



# Fourth Street School

## Social Skills & Transition Groups Enrollment Form 2012-2013

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Student's Grade 2012-2013: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ M/W: \_\_\_\_\_ F/W: \_\_\_\_\_ Alt. Numbers: \_\_\_\_\_

Mom's Email Address \_\_\_\_\_

Dad's Email Address \_\_\_\_\_

Has your child received previous psychological or academic testing? \_\_\_\_\_

If so by whom: \_\_\_\_\_

Private Counseling? \_\_\_\_\_

Does your child have a particular learning difference or diagnosis of which you are already aware?

If so, what or in what area(s)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your concerns with your child's behavior?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other members of your household and ages:

\_\_\_\_\_  
\_\_\_\_\_

Other adults (besides those listed above) who might pick your child up from group: (name and relationship):

\_\_\_\_\_  
\_\_\_\_\_



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## *Authorization for Emergency Medical Care*

I hereby authorize any staff member of the Fourth Street School to give consent for any and all necessary medical for my child \_\_\_\_\_, while he or she is in the custody of the Fourth Street School faculty or staff.

Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ SS#: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

Student's SS#: \_\_\_\_\_ Medicine Allergies: \_\_\_\_\_

Any Special Health Problems: \_\_\_\_\_

Alternative persons to contact if parents cannot be reached (names and relationship):

\_\_\_\_\_  
Name Phone #

\_\_\_\_\_  
Name Phone #

\_\_\_\_\_  
Name Phone #