

**THE MADDUX SCHOOL**

11614 Seven Locks Road ♦ Rockville ♦ Maryland 20854 ♦ 301-469-0223 ♦ [www.madduxschool.org](http://www.madduxschool.org)

**2017-18 STUDENT INFORMATION FORM**

We update our records at least annually. Please be sure to complete **BOTH SIDES**. (*Information will be treated as confidential*) Thank you for your assistance.

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**First Name:** \_\_\_\_\_ **Middle Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Prefers to be called:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Current mailing address:** \_\_\_\_\_ **Other parent/guardian to receive mailings:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

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**Student lives with:**  mother  father  both  other (name) \_\_\_\_\_

sibling(s) \_\_\_\_\_  
(names & ages) \_\_\_\_\_

**Legal Custody:**  mother  father  both  other (name) \_\_\_\_\_

**Send email notices to:**  mother  father  both  other (name) \_\_\_\_\_

**School reports to:**  mother  father  both  other (name) \_\_\_\_\_

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**Mother**           **Father**           **Guardian**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Business:** \_\_\_\_\_ **Profession:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Business Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_

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**Mother**           **Father**           **Guardian**

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Business:** \_\_\_\_\_ **Profession:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_

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**PLEASE COMPLETE REVERSE SIDE**

Student Name \_\_\_\_\_

Other contacts in case of an emergency – Names, cell, home & work phone numbers:

1. \_\_\_\_\_

2. \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Other Physician(s) we may need to contact: \_\_\_\_\_ Phone \_\_\_\_\_

1. Does your child take any medications? \_\_\_\_\_

If yes, please complete **Medication Order Form** for medications taken at home and/or school.

2. For what condition is medication needed? \_\_\_\_\_

3. Does your child have any allergies? \_\_\_\_\_ To what? \_\_\_\_\_

Explain allergic reaction \_\_\_\_\_

4. Is your child on a special diet? \_\_\_\_\_ If so, what are the special instructions? \_\_\_\_\_

5. Has your child ever been stung by a bee? \_\_\_\_\_ Was there an unusual reaction? \_\_\_\_\_

6. Has your child had a seizure? \_\_\_\_\_

Care procedures during seizure \_\_\_\_\_

Care procedures after seizure \_\_\_\_\_

7. Any additional medical information we should know? \_\_\_\_\_

**8. IS THERE ANY SPECIAL INFORMATION WE NEED IF YOUR CHILD HAS TO GO TO THE EMERGENCY ROOM?**

Please sign and date.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date