S.O.A.R.S. ALTERNATIVE SCHOOL STUDENT INFORMATION

Student's Name: _____
(First) (M.I) (Last)

Student's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Birth date: _____ Birthplace: _____

Ethnic Group: (Please circle one) American Indian Hispanic Black
White Other: _____

Living With: Father Mother Foster Grandparent
Stepfather Stepmother Guardian Other

Father's Name: _____

Father's Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Occupation: _____ Employer: _____

Mother's Name: _____

Mother's Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT: (local contact only please)

NAME: _____ Phone: _____

I authorize emergency treatment by physician named below, or staff of any hospital emergency room: ___Yes ___ No

Signature: _____ Doctor Name: _____

Emergency information: (Circle and note below) Allergies Diabetes Seizures

_____