

Central Virginia Governor's School for Science & Technology Family Information and Emergency Medical Form

Please print legibly.

STUDENT INFORMATION

Last Name _____ First _____ MI _____

Nick-Name (if filled in, this is the name that will be used on unofficial documents) _____

Home Address _____ City _____ Zip _____

Student Email _____ Home High School _____

Birth Date (mo/day/year) _____ Cell Phone _____

Last Four Digits of Student's Social Security Number (Required for some internship placements) _____

Older sibling attended CVGS? (Used to avoid repetitive mailings from CVGS Foundation) Yes No

Information for Parents/Guardians With Whom the Student Lives (those with primary physical custody)

Parent/Guardian 1 Name _____ **Title** (Circle one): Dr. Mr. Mrs. Ms.

Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Email Address (used for Gov School events notifications) _____

Parent/Guardian 2 Name _____ **Title** (Circle one): Dr. Mr. Mrs. Ms.

Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Email Address (used for Gov School events notifications) _____

Information for the Parent/Guardian With Whom the Student Does NOT Live (does not have primary custody)

Parent/Guardian 3 Name _____ **Title** (Circle one): Dr. Mr. Mrs. Ms.

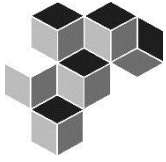
Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Work Phone _____

Should this individual be used as an emergency contact? Yes No

Please complete the back of this form and sign and date it prior to returning.



**Central Virginia Governor's School for Science & Technology
Family Information and Emergency Medical Form (Back Page)**

Student Name: _____

EMERGENCY CONTACT LIST: (In the unlikely case of an emergency, if we can't reach a parent/guardian, we will attempt to contact the individuals listed below in the order listed.)

Contact 1 Name _____ Home Phone _____

Relationship to Student/Family _____ Cell _____

Contact 2 Name _____ Home Phone _____

Relationship to Student/Family _____ Cell _____

MEDICAL INFORMATION: In order to participate in overnight field trips and internships, students must have medical insurance. For information about school insurance, contact your child's home high school. For information about Free Health Insurance for Children, a program of the Commonwealth of Virginia, please call 1-866-873-2647.

Medical Insurance Provider Name _____ Phone _____

Policy Holder _____ Policy Number _____

Primary Care Physician Name _____ Phone _____

Primary Care Physician's Group's Name (if applicable) _____

Please list any and all student allergies (drug, food, etc.). _____

Please list any and all serious/chronic medical conditions, such as hearing or vision impairment, asthma, diabetes, seizures, anxiety, depression, and so on, and please note if the student has an EPI-Pen, inhaler, insulin pump, etc.

Please list any and all medications the student is currently taking. _____

MEDICAL RELEASE

By signing below the parent/guardian agrees that he or she is responsible for promptly notifying CVGS of any changes to the information provided on this form. This includes changes to contact information, medical concerns, medical providers, and so on. The parent/guardian also authorizes the school and/or medical care provider to make decisions and to provide medical care for the student according to their best judgment. The parent/guardian also agrees to pay any expenses incurred, including ambulance transportation if necessary.

Parent/Guardian Signature _____

Date _____