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 <u>With Whom the Student Lives</u> (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 <u>With Whom the Student Does NOT Live</u> (does <u>not</u> 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** _____