

2020 - 2021

Cedar Hill ISD DAEP STUDENT INFORMATION

Information to be provided by parent or guardian

Student Last Name:		Student First Name:		Middle Initial
Social Security Number: — — —		Age:	Date of Birth:	<input type="checkbox"/> Male or <input type="checkbox"/> Female
Mailing Address: Street, Apartment or PO Box Number City ZIP Code		Residence Address: Street or Apartment City ZIP Code		
Ethnic Background: (Check One) <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other _____				
Guardian: (Check One) <input type="checkbox"/> Mother & Father <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Other _____ Please specify relationship				
Father's / Male Guardian Name		Place of Employment:	Home Phone:	Work / Cell Phone:
Mother's / Female Guardian Name		Place of Employment:	Home Phone:	Work / Cell Phone:
Emergency contact		Relationship to Student	Home Phone:	Work / Cell Phone:
Emergency contact		Relationship to Student	Home Phone:	Work / Cell Phone:
Is the student on probation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Probation officer:		
Has the student ever failed a grade, or been denied credits to make the next classification in high school? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Has the student ever been placed in a Disciplinary Alternative Education Program? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Email address: Hm _____ Wk. _____				
<u>EMERGENCY MEDICAL DATA</u>				
IN EXTREME EMERGENCY, WE WILL ATTEMPT TO REACH YOU IMMEDIATELY. PLEASE COMPLETE INFORMATION BELOW TO BE USED IN SUCH EMERGENCY				
HOSPITAL		ADDF	PHONE #	
PHYSICIAN		ADD	PHONE #	
Please list any medication conditions/allergies _____				
Please list medications student takes regularly _____				
Parent / Guardian Signature: _____				