SAUGERTIES APPLICATION TO PARTICIPATE IN ULSTER BOCES

Student Full Name ____

Your son/daughter filled out a simple Google Doc. application for BOCES. We have since been told that BOCES need's additional information. Please use the QR code below to access the long version of the application for BOCES. The demographic information that you provide (name, address, email, phone number, etc.) will be shared with Ulster BOCES. This application is also accessible via the Counseling Center school website.

PARENTAL PERMISSION REQUIRED

I approve of my student's registration at the Career & Technical Center and authorize Saugerties to share my student's demographic information with Ulster BOCES as part of the application process.

Parent/Guardian Name Printed ______________________ Signature ______________________Date ___________

Student Name Printed ____________________________ Signature ______________________Date___________

PLEASE SEE BACK AND COMPLETE BOCES EMERGENCY INFORMATION FORM

ULSTER COUNTY BOCES CAREER & TECHNICAL CENTER
EMERGENCY INFORMATION FORM

THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: ______________________________ Home School: _______________

Mailing Address: ____

Date of Birth ___/___/___ Home #: ______________ Cell #: ________________

Is student taking any medication? YES _____ NO______

Name of medication & dosage: ____

Reason for medication: _________________________ Time medication is given: _________

Allergies: __________________ Medical conditions that require care: _________________

Doctor's Name: _____________________________ Phone number: _______________

Mother's Name: _____________________________ Home #: __________________
Work #: ______________ Cell #: __________________

Father's Name: _____________________________ Home #: __________________
Work #: ______________ Cell #: __________________

Legal Guardian's Name: ______________________ Home #: __________________
Work #: ______________ Cell #: __________________

Emergency Contact Person 1: ______________________ Phone #: _______________
Not listed above – Name & relationship

Emergency Contact Person 2: ______________________ Phone #: _______________
Not listed above – Name & relationship

____________________ ____
Date Signature of Parent/Guardian

THIS SECTION TO BE COMPLETED BY SCHOOL NURSE

Is there a condition present that requires special care? YES _____ NO _____

List any acute or chronic illnesses or medical conditions: ______________________________

Physical restrictions: ___________________________ Allergies: _____________________

Medication: ____

Date of last Tetanus injection: _____/_____/_____ Date of 1ST Polio Vaccination____/____/_____
Date of 1st MMR _____/_____/_____ Date of 2nd MMR _____/_____/______

School Nurse Signature: _____________________________ Date: _____/_____/_____