



**CROSS ROAD CHILDREN'S CENTER
STUDENT INFORMATION**

LAST NAME: _____ FIRST NAME: _____

BIRTHDATE ___/___/___

SEX: M () F () SOC SEC #: _____ - _____ - _____ CLASS: _____

ENROLL DATE: _____ START DATE: _____

DOCTOR: _____ PHONE #: _____ - _____ - _____

DENTIST: _____ PHONE #: _____ - _____ - _____

SPECIALIST: _____ PHONE #: _____ - _____ - _____

FOOD ALLERGIES: _____

SPECIAL DIET RESTRICTIONS (A doctor's statement of medical need or a written parental statement of religious belief is needed.): _____

OTHER ALLERGIES: _____

IMMUNIZATION RECORDS IN PUBLIC SCHOOL? YES () NO ()

DATE OF LAST PHYSICAL: _____

ANY SPECIAL NEEDS TO BE CONSIDERED IN CARING FOR YOUR CHILD? _____
