

## Student Face Sheet

The Department of Education and the Department of early Education and Care requires this form to be filled out each year. Please complete this form and return it to the Student Services Department.

Student Name:	<div style="display: flex; justify-content: space-around; font-size: small;"> <span>First</span> <span>Middle</span> <span>Last</span> </div>	Date of Birth:
Birthplace City:		Birthplace State/Country:
Gender (Male or Female):	Hair color:	Color of eyes:
Height (Ft/Inches): _____ / _____	Weight (Pounds/Ounces): _____ / _____	
Glasses (Yes or No):	Hearing Aids (Yes or No):	Left/Right/Both
Allergies (Yes or No):	If yes, list:	<hr/> <hr/> <hr/> <hr/>
Dietary Restrictions (Yes or No):	If yes, list:	<hr/> <hr/> <hr/> <hr/>
Seizures (Yes or No):	Identifying Marks:	<hr/> <hr/> <hr/> <hr/>
Date of Last Physical:		Date of Last Dental:
Social Security:		Race:
Citizenship:		
Home Address: (Street)		
Home Address: (City)		State:
Zip Code:	Phone Number:	Primary Language:

Student Face Sheet (page 2):			
<b>Father's Name:</b>		Birthplace:	
Marital Status:		Home Phone:	
Address (Street)		Work Phone:	
City:		Cell Phone	
State:	Zip Code:	Email:	
Occupation:		Employer:	
<b>Mother's Name:</b>		Birthplace:	
Marital Status:		Home Phone:	
Address (Street)		Work Phone:	
City:		Cell Phone	
State:	Zip Code:	Email:	
Occupation:		Employer:	
<b>LEGAL STATUS:</b>			
If under 18 years old custody status: (pick one)		<input type="checkbox"/> Mother	<input type="checkbox"/> Father
		<input type="checkbox"/> Joint	
If 18 years or over guardianship status: (pick one)		<input type="checkbox"/> Student is own guardian	
<input type="checkbox"/> Shared decision with parents in educational decisions		<input type="checkbox"/> Court appointed guardian	
If court appointed legal guardian is someone other than the parent, please complete information below:			
Name:		Home phone:	
Agency Name if applicable:		Work Phone:	
Address (Street)		Cell Phone:	
City:		Fax:	
State:	Zip Code:	Email:	
<b>Emergency Contacts: Two emergency contacts must be provided (other than Mother &amp; Father)</b>			
1.	Name:	Home phone:	
	Address (Street):	Work phone:	
	City:	State:	Cell Phone:
	Zip Code:	Relationship to student:	

2.	Name:	Home phone:	
	Address (Street):	Work phone:	
	City:	State:	Cell Phone:
	Zip Code:	Relationship to student:	

**Student Contact List:** (Please list people other than parents/guardian who have your permission to contact your child while they are under the care of the Cardinal Cushing Center at Hanover. Biological parents are always approved visitors unless we receive documentation from the courts stating otherwise.)

Name:	Relationship to student	Visits: (On) On-campus, (Off) Off campus, (B) Both, (S) Monitored	Student's medication can be released to this person. (Y) Yes (N) No	Phone/Email (Y) Yes (N) No (S) Supervised	Written Correspondence (Y) Yes (N) No (P) Progress Reports Only
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

**Medications**

Medication	Dosages	Times	Prescribed by:
1.			
2.			
3.			
4.			

Medications (continued)	Dosages	Times	Prescribed by:
5.			
6.			
7.			
8.			
9.			
10.			
Primary Physician:			
Parent Signature:		Date:	

**To be filled out by Cardinal Cushing Staff:**

What are the student's self-preservation skills (Including but not limited to evacuation of a building, pedestrian

skills, etc.)			
<b>SASID #:</b>		<b>Grade Level:</b>	
<b>IEP Dates:</b>			
<b>Funding Source(s):</b>	1.	<b>Admission date:</b>	
	2.		
	3.		
<b>Funding School System:</b>		<b>Liaison:</b>	
Address:		<b>Title:</b>	
City:		<b>Phone:</b>	
State:		<b>Fax:</b>	
Zip code:		<b>Email Address:</b>	
<b>Referral Source:</b>		<b>Liaison:</b>	
School/Agency:		<b>Title:</b>	
Address:		<b>Phone:</b>	
City:		<b>Fax:</b>	
State:		<b>Email Address:</b>	
Zip code:			
<b>Other Agencies Involved:</b>			
<b>Agency Address:</b>		<b>Liaison:</b>	
Address:		<b>Title:</b>	
City:		<b>Phone:</b>	
State:		<b>Fax:</b>	
Zip code:		<b>Email Address:</b>	
How is this agency involved? (select appropriate choice)	<input type="checkbox"/> Funding only <input type="checkbox"/> Other involved agency <input type="checkbox"/> Program oversight <input type="checkbox"/> Program oversight & funding <input type="checkbox"/> Shared funding <input type="checkbox"/> Other:		
<b>Other Agencies Involved:</b>		<b>How involved?</b>	
<b>Agency Address:</b>		<b>Liaison:</b>	
Address:		<b>Title:</b>	
City:		<b>Phone:</b>	
State:		<b>Fax:</b>	
Zip code:		<b>Email Address:</b>	
How is this agency involved? (select appropriate choice)	<input type="checkbox"/> Funding only <input type="checkbox"/> Other involved agency <input type="checkbox"/> Program oversight <input type="checkbox"/> Program oversight & funding <input type="checkbox"/> Shared funding <input type="checkbox"/> Other:		
<b>Other Agencies Involved:</b>		<b>How involved?</b>	
<b>Agency Address:</b>		<b>Liaison:</b>	

Address:		Title:	
City:		Phone:	
State:		Fax:	
Zip code:		Email Address:	
How is this agency involved? (select appropriate choice)	<input type="checkbox"/> Funding only <input type="checkbox"/> Other involved agency <input type="checkbox"/> Program oversight <input type="checkbox"/> Program oversight & funding <input type="checkbox"/> Shared funding <input type="checkbox"/> Other:		
<b>Transportation Company:</b>		Phone #:	
		Contact:	
		Phone #:	
		Contact:	
<b>Discharge Date:</b>			
<b>Location after discharge:</b>		Liaison:	
<b>Agency Address:</b>		Title:	
City:		Phone:	
State:		Fax:	
Zip code:		Email Address:	
<b>Follow-up responsibility:</b>			

2/9/09