LYNCHBURG COMMUNITY ACTION GROUP
(PLEASE PRINT)

For Official Use Only Child plus ID_____ Family Income %_____Proof of Residence_____

Student Information

INTIAL HERE IF WE MAY CONTACT YOU BY TEXT OR E-MAIL_____

New Student_____ Returning Student _____Foster Child_____

Name Last_____ First_____ Middle_____

Sex_____ Race_____

Address _____Phone _____Phone_____

Social Security Card _____Birth Date _____Birth Certificate #_____

COMPLETE IF ONE ADULT IN HOUSEHOLD

Parent/Guardian Name_____Relationship_____

Age _____Date of Birth_____ Social Security Card#_____

Residence Address_____Zip_____

Mailing Address_____Zip_____

Home Phone_____ Employer _____Work Phone_____

Are you paid weekly_____ twice a month _____every two-weeks_____ monthly_____

Attending College_____ or Training Program _____

Shift worked First_____ Second _____Third_____

E-mail Address_____ Cell phone _____

COMPLETE IF TWO ADULTS IN HOUSEHOLD

Parent/Guardian Name_____Relationship_____

Age of parent_____ Date of Birth_____ Social Security Card#_____

Residence Address_____Zip_____

Home Phone_____ Employer_____ Work Phone_____

Are you paid weekly _____twice a month _____ every two weeks_____ monthly _____

E-mail Address_____ Cell Phone_____

NUMBER OF CHILDREN LIVING IN THE HOUSEHOLD_____

Name _____Date of Birth _____Race____

Name _____Date of Birth _____Race____

Name _____Date of Birth _____Race____

Name _____Date of Birth _____Race____

Name _____Date of Birth _____Race____

Additional Emergency Contacts In the event there is an emergency and the parents/ guardians above are not available, whom should we contact?

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Name _____ Phone_____ Relationship_____

Name _____Phone_____ Relationship_____

Medical Information

Physician's Name _____Phone_____

List all allergies, including drug and food allergies_____

List all Special Needs_____ IEP with School System_____

List any serious chronic medical condition the child may have, such as heart problems, asthma, diabetes, seizures, etc. _____

Date_____ Parent/Guardian's Signature_____