

Sandman Consolidated School  
838 Seashore Road  
Cape May, NJ 08204  
Telephone: (609) 884-9410  
Fax: (609) 884-9412

LOWER TOWNSHIP ELEMENTARY SCHOOL DISTRICT  
834 SEASHORE ROAD  
CAPE MAY, NEW JERSEY 08204

Memorial School  
2600 Bayshore Road  
Villas, NJ 08251  
Telephone: (609) 884-9430  
Fax: (609) 886-0515

Maud Abrams School  
714 Townbank Road  
Cape May, NJ 08204  
Telephone: (609) 884-9420  
Fax: (609) 884-9421

TELEPHONE: (609) 884-9400  
FAX: (609) 884-1821

Carl T. Mitnick School  
905 Seashore Road  
Cape May, NJ 08204  
Telephone: (609) 884-9470  
Fax: (609) 884-9481

**MITNICK SCHOOL**

Dear Parents/Guardians:

In order to ensure that the information in our office is current, we are asking your assistance in completing this form and returning it to school as soon as possible. **All information is confidential.**

Your cooperation is greatly appreciated.

*Sherry Bosch, Principal*

STUDENT'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

TEACHER/GRADE \_\_\_\_\_

PARENTS'/GUARDIANS' NAMES \_\_\_\_\_

IF STUDENT **DOES NOT** LIVE WITH BOTH PARENTS, PLEASE COMPLETE THE FOLLOWING:

STUDENT LIVES WITH:	RELATIONSHIP TO STUDENT:
_____	_____
_____	_____
IF THERE ARE CUSTODY ISSUES REGARDING YOUR CHILD, PLEASE COMPLETE THE INFORMATION BELOW AND <b>PROVIDE DOCUMENTATION.</b>	
Please circle one:      Joint Custodial Parent      Non-Custodial Parent	
NAME _____	RELATIONSHIP _____
ADDRESS _____	PHONE # _____
_____	

PLEASE COMPLETE THE FOLLOWING:

STUDENT'S HOME ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

SISTERS/BROTHERS	BIRTHDATE	TEACHER	SCHOOL
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PLEASE COMPLETE BOTH SIDES.**

PLEASE PROVIDE WORKPLACE/WORKPHONE FOR PARENTS/GUARDIANS AND UPDATE DURING THE YEAR AS NECESSARY:

NAME	WORKPLACE	WORKPHONE	CELL PHONE

PLEASE PROVIDE **LOCAL EMERGENCY CONTACT** (SOMEONE WHO CAN BE REACHED DURING SCHOOL HOURS) AND UPDATE DURING THE YEAR AS NECESSARY:

NAME/RELATIONSHIP	WORKPLACE	PHONE	CELL PHONE

PLEASE PROVIDE BUS INFORMATION:

BUS IN:	BUS STOP:
BUS OUT:	BUS STOP:

IF YOUR CHILD IS BUSSED TO OR FROM A LOCATION **OTHER THAN YOUR HOME ADDRESS**, PLEASE PROVIDE THE NAME, ADDRESS, AND PHONE NUMBER OF THE PERSON AT THAT ADDRESS (i.e. BABYSITTER):

NAME/RELATIONSHIP	ADDRESS
<b>PHONE</b>	<b>CELL PHONE</b>

**PLEASE PROVIDE THE FOLLOWING HEALTH INFORMATION:**

Medical concerns should be shared with Susan Godfrey, the school nurse at MITNICK SCHOOL.

RECENT HEALTH PROBLEMS:

CURRENT MEDICATIONS:

MEDICAL CONDITIONS/PHYSICAL RESTRICTIONS (i.e., ASTHMA, HEART CONDITION, ETC.):

**IF THERE ARE ANY RESTRICTIONS ON WHO MAY CONTACT OR PICK UP YOUR CHILD FROM SCHOOL, PLEASE DESCRIBE. PLEASE ATTACH COPIES OF ANY LEGAL PAPERS REGARDING THIS MATTER:**

**PLEASE LIST ANY OTHER PERTINENT INFORMATION NEEDED BY THE SCHOOL OFFICE.**

**PLEASE COMPLETE BOTH SIDES.**