ST. VINCENT'S SPECIAL NEEDS SERVICES - STUDENT INFORMATION

Student's Name: (first)	(last)	**DOB:**

Sex: ☐ **Male** ☐ **Female**

Address: (street)	(city)	(zip code)	Home Phone:

Mother's Name:	Address:	Cell Phone:
E-Mail Address:		
Employer's Name:	Address:	Work Phone:
Father's Name:	Address:	Cell Phone:
E-Mail Address:		
Employer's Name:	Address:	Work Phone:
Legal Guardian's Name (if Other than Parent)/Address:		
Home Phone:	Cell Phone:	Work Phone:

EMERGENCY CONTACTS: List 3 person's phone #'s who we may contact and release your child to in an emergency. The persons identified will only be contacted after reasonable attempts to reach the child's parent/guardian. Please list names in order of who we should contact first & by the first # we should call.

Name:	**1st#**	**2nd#**
Name:	**1st#**	**2nd#**
Name:	**1st#**	**2nd#**

MEDICAL INSURANCE / MEDICAL BENEFIT INFORMATION

1. Primary Ins Carrier:	**Policy #:**	**Group #:**
Address:		**Phone:**
2. Secondary Ins. Carrier:	**Policy #:**	**Group #:**
Address:		**Phone:**
Medicaid Title XIX#:	**Name/Address:**	**Phone:**
Managed Medicaid ID#:	**Name/Address:**	**Phone:**

****Please contact Administrative Assistant with any changes 203-386-2742**

Initial:________________________ **Date:**_________________