

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

MAUD ABRAMS 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.

Barbara Dalrymple, 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 PROVIDE DOCUMENTATION.	
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
PHONE	CELL PHONE

PLEASE PROVIDE THE FOLLOWING HEALTH INFORMATION:

Medical concerns should be shared with VIRGINIA GOWEN, the school nurse at MAUD ABRAMS 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.