

# MISSION TRAILS REGIONAL OCCUPATIONAL PROGRAM

867 East Laurel Drive, Salinas, CA 93905 (831) 753-4209

## STUDENT INFORMATION SHEET

				<b>STUDENT ID NUMBER:</b>	
<b>LAST NAME:</b>			<b>FIRST:</b>		<b>MI:</b>
<b>STREET ADDRESS</b>					
<b>CITY:</b>		<b>ST:</b>	<b>ZIP:</b>	<b>SS#</b>	
<b>HOME PHONE:</b>		<b>AGE:</b>	<b>BIRTH DATE:</b>		<b>MALE: ___ FEMALE ___</b>
<b>GRADE: 9 10 11 12</b>		<b>SCHOOL:</b>		<b>COUNSELOR:</b>	
<b>CIRCLE ETHNICITY:</b> 1. AM INDIAN-ALASKA NATIVE      5. HISPANIC 2. ASIAN                                      6. BLACK 3. PACIFIC ISLANDER              7. WHITE 4. FILIPINO				<b>CIRCLE TRANSPORTATION:</b>  WALK    DRIVE    BUS    RIDE  OTHER:	

The Regional Occupational Program is in compliance with the following federal and state regulations: Title VI and VII of the Civil Rights Act; the California Fair Employment Practices Act; Chapter 4 Division 1 of Title 5; the California Administrative Code; and Title IX (Nondiscrimination on the basis of sex) of the Educational Amendments of 1972.

**PARENTAL DATA AND PERMISSION FOR EMERGENCY MEDICAL TREATMENT:**

<b>FATHER'S NAME:</b>	<b>HOME PHONE:</b>
<b>FATHER'S PLACE OF EMPLOYMENT:</b>	<b>BUSINESS PHONE:</b>
<b>MOTHER'S NAME:</b>	<b>HOME PHONE:</b>
<b>MOTHER'S PLACE OF EMPLOYMENT:</b>	<b>BUSINESS PHONE:</b>

In a medical emergency, the school will make every effort to contact a student's parents. If a parent cannot be reached by telephone, the school has my permission to seek medical aid.

**FAMILY PHYSICIAN:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE** **DATE:**

\_\_\_\_\_  
**ROP COORDINATOR SIGNATURE**