

STUDENT REGISTRATION FORM

Please fill out this form COMPLETELY and/or make any necessary changes to existing information. If area does not apply, put N/A in space. Sign and date form.

SCHOOL: _____ I.D.#: _____ BUS: _____
GRADE: _____ HOMEROOM: _____

STUDENT'S FULL NAME (Last, First, Middle): _____		SEX: _____
DATE OF ENROLLMENT: _____	DATE OF BIRTH: _____	
DATE OF WITHDRAWAL: _____	BIRTHPLACE (City,Co.,State): _____	
STUDENT'S HOME ADDRESS: _____ _____	INTERNET E-MAIL ADDRESS: _____	
PHONE: _____	_____	

**Please indicate racial/ethnic background: (Circle One) White/Non-Hispanic Hispanic White/Hispanic
Black/Non-Hispanic Black/White American Indian or Alaskan Native Asian or Pacific Islander Multi Other _____
Is a language other than English spoken in your home? NO YES(specify) _____
Does your child speak a language other than English? NO YES (specify) _____

STUDENT LIVES WITH (Both Parents, Mother, Father, Stepfather, Stepmother, Grandparents, etc.):

LEGAL CUSTODY GRANTED TO:

MOTHER'S NAME: _____ ADDRESS: _____ PHONE:(H) _____
(W) _____

PLACE OF EMPLOYMENT: _____ CELL: _____

FATHER'S NAME: _____ ADDRESS: _____ PHONE:(H) _____
(W) _____

PLACE OF EMPLOYMENT: _____ CELL: _____

GUARDIAN: _____ PHONE: (H) _____
(W) _____

NAMES & AGES OF BROTHERS & SISTERS: _____ CELL: _____

LIST TWO LOCAL PERSONS & THE RELATIONSHIP TO STUDENT (Relative, neighbor, friend, babysitter, etc.) WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED TO ACCOMPANY YOUR CHILD HOME, TO THE DOCTOR OR HOSPITAL IF NECESSARY:

*If applicable, please list babysitter as first contact person and indicate "sitter"

NAME/ADDRESS: _____ PHONE: (H) _____
_____ (W) _____
_____ CELL: _____

NAME/ADDRESS: _____ PHONE:(H) _____
_____ (W) _____
_____ CELL: _____

IN CASE MY CHILD NEEDS EMERGENCY CARE AND I CANNOT BE REACHED, PLEASE CALL:

DOCTOR: _____ PHONE: _____ DENTIST: _____ PHONE: _____

LIST ANY SPECIAL NEEDS OR MEDICAL PROBLEMS: _____

I authorize school official(s) to transport/accompany my child to a hospital or any medical treatment facility and approve medical personnel to provide treatment for my child of an emergency nature.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____