AFC School District #275

CONFIDENTIAL / EMERGENCY / REGISTRATION FORM

Registration Date____________

Student ID Number ________________

Date of Admittance________________

Print Last Name of Child | First Name | Middle Initial

Address | City | State | P.O. Box | Apt.#

Tel. Number | ☐ Unlisted | Mom's Cell Phone | Dad's Cell Phone

Sex | Student Social Security No. | Email Address | Date of Birth | Place of Birth

Ethnicity: Check One

☐=American Indian/Alaskan (A) ☐=Asian/Pacific Islander (B) ☐=Black [*not Hispanic*] (C) ☐=Hispanic (D) ☐=White (E)

Primary Language spoken at home: ____________________

Full Name of Parent(s) / Guardian(s)	Relationship & Date of Birth	Marital Status *(married/divorced/ separated)*		Occupation	Parent/Guardian's Place of Employment	Firm's Telephone No.
	D.O.B. ______ Mother					
	D.O.B. ______ Father					

Pupil lives with: ____________________ Relationship: ____________

PLEASE LIST THE FULL NAMES OF ALL THE STUDENT'S BROTHERS AND SISTERS

Last Name	First Name	Relationship	Age	Place s/he attends school

Please name any other individuals living with family.

____

____

____

____

THE FOLLOWING MUST BE FILLED OUT:

List 2 neighbors, relatives, or friends with access to transportation who will assume temporary care of your child if you cannot be reached.

Name ____________ Address ____________ Tel. No. ____________ Cell No. ____________

Name ____________ Address ____________ Tel. No. ____________ Cell No. ____________

Last School Attended: ____________ Grade: ______ Address: ____________ Telephone: ______ Date Left: ______

Where you receiving special services? *(check all that apply)* ☐ **Self contained** ☐ **Special Ed.** ☐ **Resource** ☐ **Adaptive Physical Ed.** ☐ **Counseling** ☐ **Individual Ed. Plan (IEP)** ☐ **ESL**

NOTE: Please be sure to complete the back side of this form.

CONFIDENTIAL HEALTH INFORMATION *If you answer yes to any of the questions listed below, please explain further:*

If your child has any condition which calls for special care or restricted activity, please note it here.

Does your child have any allergies? (food, medications, bee stings, pollen, etc.) ☐ **No** ☐ **Yes** **Explain:**

Has your child ever needed medication or medical attention in the past for an allergic reaction? ☐ **No** ☐ **Yes** **Explain:**

Does your child have asthma? (If Yes) What year was he/she diagnosed? ☐ **No** ☐ **Yes** **Explain:**

Has your child ever been hospitalized for a serious illness or injury? ☐ **No** ☐ **Yes** **Explain:**

Does your child have any physical condition of which the school should be aware? ☐ **No** ☐ **Yes** **Explain:**

Does your child have a hearing problem? ☐ **No** ☐ **Yes** **Explain:**

Does your child wear glasses/contacts? ☐ **No** ☐ **Yes** **Explain:**

Is your child on any medication? ☐ **No** ☐ **Yes** *What is the name of the medication(s) and reason for taking it?*

Name of medication(s) ____________________ **Reason for medication(s)** ____________________

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ALL MEDICATION TO BE GIVEN IN SCHOOL MUST HAVE A DOCTOR'S WRITTEN ORDER AND BE IN A LABELED PHARMACY CONTAINER.

School health programs state that students must present evidence of immunization at school entry. If a student cannot present acceptable evidence of immunization at entry he/she must be excluded.

Please indicate with a check mark if this child has any of the following health problems

☐ BONE OR JOINT DISEASE	☐ THROAT INFECTIONS (FREQUENT)	☐ CHICKEN POX (YEAR ________)	☐ DIABETES
☐ CONVULSIONS/SEIZURES	☐ DENTAL PROBLEMS	☐ EAR INFECTIONS	☐ ECZEMA
☐ MENSTRUAL PROBLEMS	☐ HEADACHES (FREQUENT)	☐ HEART PROBLEMS/MURMURS	☐ KIDNEY PROBLEMS

Any other health problem? (Please Explain) ____________________

In the event of an accident or serious illness, I hereby authorize the school to contact the physician indicated below and to follow his/her instructions, if the school is unable to reach me. If it is impossible to contact the physician, or if the problem needs immediate attention, the school may make whatever arrangement they deem necessary for the well being of my child. If this information changes during the school year, please contact the child's school.

Local Physician's Name ____________________ Address ____________________ Telephone ____________

Local Dentist's Name ____________________ Address ____________________ Telephone ____________

PARENT/GUARDIAN'S SIGNATURE ____________________ **Date** ____________