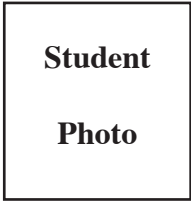


**Elementary School Registration Information**  
**School Name** \_\_\_\_\_  
**Date** \_\_\_\_\_



**STUDENT INFORMATION**

Student's name \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_  
(Last) (First) (Middle)

Sex:  Male  Female Date of Birth \_\_\_\_\_ Social Security number \_\_\_\_\_

Race:  White  Black or African American  Asian  Hispanic/Latino  American Indian or Alaska Native  
 Native Hawaiian or Other Pacific Islander  Multi-racial

If not born in the USA, what was the date student was first enrolled in school in the US? (DD/MM/YYYY) \_\_\_\_\_

If not born in the USA, what is country of birth? \_\_\_\_\_

Name of school student last attended \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Has student ever attended a Columbus school?  Yes  No If yes, give year & name of school \_\_\_\_\_

Has student ever been served by a special education program?  Yes  No Gifted Education?  Yes  No

What was the language(s) the student first learned to speak? \_\_\_\_\_

What language(s) does the student speak at home? \_\_\_\_\_ What language(s) does the student speak most often? \_\_\_\_\_

**PARENT/LEGAL GUARDIAN INFORMATION**

Father/Legal guardian \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Mother/Legal guardian \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Street address of parent: \_\_\_\_\_ Zip \_\_\_\_\_

Is either parent active duty military?  Yes  No Is either parent a civilian employed at Fort Benning?  Yes  No

Name of person with whom student lives \_\_\_\_\_

Relationship to student:  Parent  Legal Guardian  Foster Parent  Relative  Friend  Other (*Specify*) \_\_\_\_\_

May the student be checked out by both parents?  Yes  No

**TRANSPORTATION - Check all that apply**

Bus (include bus #) \_\_\_\_\_  Car rider  Walker  Before School Program  After School Program

Day Care (include Day Care name) \_\_\_\_\_ Day Care phone no. \_\_\_\_\_

**FIELD TRIP PARENTAL AUTHORIZATION**

Name of student \_\_\_\_\_ has my permission to attend all field trips scheduled for this school year. If for any reason I do **not** want my child to attend a particular field trip, I will notify the school.

**EMERGENCY CONTACT \*\*\*Please indicate an individual other than yourself\*\*\***

Name \_\_\_\_\_ Home phone \_\_\_\_\_

Work phone \_\_\_\_\_ Relationship \_\_\_\_\_

**CHILD MAY BE CHECKED OUT BY THE FOLLOWING PEOPLE \*\*\*indicate individuals other than registering person\*\*\***

Name Home Phone Work Phone Relationship to Student

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Student's Name \_\_\_\_\_

*Office Use Only*

- SS#                       Birth Certificate
- Immunization         Proof of Residency
- EED

**SIBLING INFORMATION: Brothers and sisters 18 years of age or under:**

<u>Name</u>	<u>Birthdate</u>	<u>School, or reason if not in school</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**STUDENT HEALTH RECORD**

Drug Allergy (name) \_\_\_\_\_ Severe?  Yes  No    Food Allergy (type) \_\_\_\_\_ Severe?  Yes  No

Insect Allergy (type) \_\_\_\_\_ Severe?  Yes  No    Other Allergies \_\_\_\_\_ Severe?  Yes  No

Does child use auto-injectable epinephrine? (Epi-Pen or Twin-ject)  Yes  No

- ADD/ADHD (Medication?) \_\_\_\_\_  Asthma (Rescue inhaler?)  Yes  No
- Diabetes  Type 1  Type 2    Meds: \_\_\_\_\_  Epilepsy/Seizure \_\_\_\_\_
- Heart Condition \_\_\_\_\_  Kidney Problem \_\_\_\_\_
- Sickle Cell Disease \_\_\_\_\_  Glasses  Braces  Hearing Aid
- Prosthesis \_\_\_\_\_  Physical Restriction (type) \_\_\_\_\_

Does student have a disability?     Yes     No

Does student require medication routinely?     Yes     No

List any and ALL medications student is presently taking \_\_\_\_\_

Reason for medication \_\_\_\_\_

Has student been hospitalized in the past five years?     Yes     No    Explain: \_\_\_\_\_

Is there a medical reason which prohibits this student's participation in physical education?     Yes     No    If yes, please supply a doctor's statement for school files.

Name of family doctor \_\_\_\_\_ (Last name and initials)    Doctor's phone number \_\_\_\_\_

May the Registered Nurse/Clinic Worker contact your child's physician regarding child's health care needs if necessary?     Yes     No

In the event of an emergency, a representative of the school has permission to call the doctor listed above if the parent/legal guardian cannot be reached.     Yes     No

The school has permission to call an ambulance to transport my child to the hospital in an emergency if the parent/legal guardian cannot be reached.     Yes     No    If yes, specify the hospital you would like your child to be transported to in an emergency.

- Martin Army Hospital                       Doctor's Hospital                       Medical Center                       St. Francis
- Columbus Health Clinic                       Medical Center Outpatient Clinic                       Other \_\_\_\_\_

The school has permission to screen my child's vision and hearing as a part of his/her educational evaluation.     Yes     No

The following question is optional. It is being asked in order to provide you with health insurance information:

Does your child have health insurance coverage (ex: Medicaid, Peachcare, Tri-Care, Blue Cross, etc.)?     Yes     No

\_\_\_\_\_  
*Signature of Parent/Legal Guardian*

\_\_\_\_\_  
*Date*