

MIDDLE SCHOOL REGISTRATION INFORMATION

SCHOOL NAME \_\_\_\_\_

SCHOOL YEAR \_\_\_\_\_

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Last First Middle

Sex: Male Female Race: White Black Asian Hispanic American Indian Multi-racial

Student's Address \_\_\_\_\_ ZIP \_\_\_\_\_

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

Relationship to student: Parent Legal Guardian Foster Parent Relative Friend Other \_\_\_\_\_

Name of school last attended \_\_\_\_\_

Address of last school attended \_\_\_\_\_ ZIP \_\_\_\_\_

Has student ever attended a Columbus public school? Yes No If yes, give last year of attendance \_\_\_\_\_

Name of Columbus public school of last attendance \_\_\_\_\_

Has student ever been assigned to a special education class? Yes No What kind? \_\_\_\_\_

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? \_\_\_\_\_

Father/Legal Guardian \_\_\_\_\_ Occupation \_\_\_\_\_

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

Mother/Legal Guardian \_\_\_\_\_ Occupation \_\_\_\_\_

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

Emergency phone no. \_\_\_\_\_ Person to reach at this number \_\_\_\_\_

**PERSON, OTHER THAN PARENT, AUTHORIZED TO PICK UP STUDENT:**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**SPECIAL HEALTH PROBLEMS (Check all which apply):**

- |              |                     |                      |                       |
|--------------|---------------------|----------------------|-----------------------|
| Asthma       | Epilepsy (Seizures) | Insect Sting Allergy | Environmental Allergy |
| Diabetes     | Food Allergy        | Kidney Problem       | Physical Handicap     |
| Drug Allergy | Heart Condition     | Milk Allergy         | Other (Specify below) |

Does student wear glasses? Yes No Contact lenses? Yes No Hearing aid? Yes No

Does student require medication routinely? Yes No What kind? \_\_\_\_\_

Reason or health problem for which medication is required \_\_\_\_\_

Name of family doctor \_\_\_\_\_ Doctor's phone \_\_\_\_\_

Is student a military dependent served by Martin Army Hospital? Yes No

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.

**BROTHERS AND SISTERS 18 YEARS OF AGE OR UNDER:**

Name	Birthdate	School or reason if not in school
_____	_____	_____
_____	_____	_____

In the event of an emergency, a representative of the school may call the family doctor if the Parent/Legal Guardian cannot be reached? Yes No Also, 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

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