SIS ID # _____ Revised 08/05

East Guernsey Local School District Registration Form

Today's Date _____

Student's Legal Name _____ _____ _____
First Middle Last

Student Address _____
Street or P.O. Box City Zip Code

Phone (___)_____ Student's Date of Birth _____
Month Day Year

Is student a district resident? _____ If not, is student attending through open enrollment? _____

Sex ____ Student's Native Language: _____ Student SS # _____
M – F

Student's City of Birth _____ Student Ethnic Classification. Check one:

____ White ____ Black ____ Hispanic ____ Asian ___ American Indian ___ Multi-Racial

School District Last Attended _____

School Building Last Attended _____

Address of Building Last Attended _____

_____

Phone Number of Building Last Attended (___) _____

Last Day of Attendance at Previous School _____ Current Grade Level _____
Month Day Year

Previous Address _____
Street City State Zip Code

Has this student previously been enrolled in the East Guernsey School District? _____
Yes – No

If previously enrolled, last grade and building attended _____ _____

Does this student take any prescription medication? _____ If yes, type and dosage:

_____

Is there any type of legal custody order/paper on this student? _____
Yes – No

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Father _____ **Stepfather** _____

Address _____ Address _____

_____ Address _____

Employment _____ Employment _____

Company & Location Company & Location

Education Level _____ Education Level _____

Mother _____ **Stepmother** _____

Address _____ Address _____

_____ _____

Employment _____ Employment _____

Company & Location Company & Location

Education Level _____ Education Level _____

Mother's Maiden Name: _____

Sibling Names: _____ Age _____ Grade _____

_____ Age _____ Grade _____

_____ Age _____ Grade _____

_____ Age _____ Grade _____

_____ Age _____ Grade _____

If student does not reside with parents, please provide court papers & the following information:

Name & Relationship: _____ _____

Address: _____ _(__)_____

Street City State Zip Code Phone

Legal Custodian (if other than parent): _____

Address: _____ _(__)_____

Street City State Zip Code Phone

Is this student under any current court supervision? _____ If so, please specify circumstances, supervising official:

_____

Has this student been served by any special programs such as Gifted/TAG, Title I, Speech, Special Education or a 504 plan? If so, what programs? _____

_____

For Office Use Only

Programs:
- _____ Special Ed
- _____ Gifted/TAG
- _____ Title I
- _____ Speech
- _____ 504 Plan
- _____ Homeless

Documentation :
- _____ Birth Certificate
- _____ Custody Papers
- _____ SS Number
- _____ Proof of Residence

Date Records Requested: _____

Bus # _____

Other _____

Circle One
Bus No._____AM/PM
Bus No. _____ AM/PM
Other _____

EMERGENCY MEDICAL AUTHORIZATION FORM

O.R.C. 3313.712

PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Student's Name _____ Birthdate_____ Grade _____

Home Address_____ PO Box #_____

City, State/Zip _____ Teacher_____

Student resides with (circle all that apply) mother father step-parent guardian other _____
If custody is involved with whom is the student living?_____

List the names (first and last names) of those who have authority to make decisions in an emergency situation involving the student.
Indicate on the line to the left of the name the order in which you would like contacts to be made (1st, 2nd, etc)

____ Mother: _____ Home Phone:_____ Work Phone:_____ Cell Phone:_____
Place of Employment_____

____ Father: _____ Home Phone:_____ Work Phone:_____ Cell Phone:_____
Place of Employment _____

____ Step-parent: _____ Home Phone:_____ Work Phone:_____ Cell Phone:_____
Place of Employment _____

____ Guardian: _____ Home Phone:_____ Work Phone:_____ Cell Phone:_____
Place of Employment_____

____ Other Contact : _____ Home Phone:_____ Work Phone:_____ Cell Phone:_____
Place of Employment_____

Siblings: Name:_____ Grade:_____ School:_____
Name:_____ Grade:_____ School:_____

Permission for picture publication (Newspaper, school articles, etc.): Yes_____ No _____
Permission for Tylenol for headache (Grades 9 through 12 only): Yes_____ No_____ **Must fill out district medication sheet.**

COMPLETE ONLY ONE OF THE FOLLOWING: 1. Consent for Treatment or 2. Refusal to Consent

1. CONSENT FOR TREATMENT:

I hereby give consent for the following medical care providers and local hospital to be called.

Preferred Physician: _____
Office Phone: _____
Preferred Dentist: _____
Office Phone: _____
Medical Specialist: _____
Office Phone: _____
Preferred Hospital: _____

2. REFUSAL TO CONSENT:

I do not give my consent for emergency medical treatment of my child in the event of illness or injury requiring emergency treatment. I wish the school authorities to take the following action:

_____
_____

Parent/Guardian Signature_____

Date:_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the preferred doctor indicated, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of surgery.

MEDICAL HISTORY: Facts concerning the child's medical history including **allergies, medication being taken, and any physical impairment** of which a physician and/or school personnel should be alerted:

_____
_____

Parent/Guardian Signature:_____ **Date:** _____
(consent for treatment)

School staff may be notified of above medical conditions unless otherwise notified.

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father

Mother

Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		