STUDENT REGISTRATION FORM

Student Legal Name: _____
First Middle Last

Preferred Name: _____ Date of Birth: _____

Grade: _____ City, State and Country of Birth: _____
City State Country

Home Address: _____

In what county does student reside? _____ **Mother's Maiden Name:** _____

Parent Information:

Status of biological parents (circle one): Married Divorced Separated Widowed Never Married

If divorced, who has legal custody? Mother Father Shared If shared, who is residential? _____

Are you the natural/adoptive parent(s) of the child? Yes or No ~ If no, what is your relationship to the child? _____

Father/Guardian:

Name: _____

Address: _____

_____

Land Line: _____

Personal Cell: _____

Email: _____

Place of Employment: _____

Business Phone: _____

Step-Mother (if applicable): _____

Business Phone: _____

Cell Phone: _____

Mother/Guardian:

Name: _____

Address: _____

_____

Land Line: _____

Personal Cell: _____

Email: _____

Place of Employment: _____

Business Phone: _____

Step-Father (if applicable): _____

Business Phone: _____

Cell Phone: _____

Special Services: Has your child received any of the following services? (Please circle all that apply)

Gifted Education ETR/Psychological Evaluation Individual Education Plan (IEP)or

English as a Second Language (ESL) 504 Individualized Accommodation Plan

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Last school attended _____ _____ _____ _____
Name of School City State Country

Last grade completed _____ Last date school was attended _____

Have you ever been enrolled in any other Ohio School District? Yes or No

If yes, name of last Ohio District attended _____

Have you ever been enrolled in any other US School? Yes or No

If yes, name the city, state and school _____

Are you currently expelled or suspended from your previous school district? Yes or No

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I, the undersigned, do hereby state and declare under penalty of falsification (*) that I am the parent or legal guardian of the above named student and that this registration information is true and correct.

_____ _____
Parent / Guardian Signature **Date**

(*) Falsification under Ohio Revised Code section 2921.13 is a misdemeanor of the first degree punishable by a maximum of six (6) months imprisonment or a fine of $1,000 or both. Requested information is mandated under Senate ORC Bill 140 and Education Management Information Systems (Sections 3301-0714).

EMERGENCY MEDICAL AUTHORIZATION

Student Information:

Student Name: _____ Date of Birth: _____

Grade: _____ Teacher / Team: _____

Mother: _____ Phone (day/night): _____ Cell: _____
(Circle one)

Father: _____ Phone (day/night): _____ Cell: _____
(Circle one)

Is there a legal custody order that applies to this child? Yes or No

If yes, please submit a copy of the final custody/guardianship papers to the district registrar or the guidance department in your child's building.

Emergency Contacts (if parent/guardian cannot be reached):

Name: _____ Relationship: _____ Phone: _____ Cell: _____

Name: _____ Relationship: _____ Phone: _____ Cell: _____

Name: _____ Relationship: _____ Phone: _____ Cell: _____

Emergency Care Information:

Preferred Physician: _____ Phone: _____ Fax: _____

Preferred Dentist: _____ Phone: _____ Fax: _____

Preferred Hospital: _____ Location: _____ Phone: _____
(Alternate hospital may be selected at the discretion of the responding Emergency Medical Services personnel)

Allergies and/or Specific Health Considerations: _____
(Health Alerts related to dietary concerns must be communicated directly to Mason City Schools Office of Child Nutrition by the parent or guardian.)
Medications taken by student on a daily or frequent basis: _____

PLEASE SIGN ONLY ONE OF THE FOLLOWING PARENT/GUARDIAN SIGNATURE LINES:

PART I – TO GRANT CONSENT

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 above-named doctor, 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 such surgery.
Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____
_____
_____

Signature of Parent/Guardian: _____ Date: _____
Address: _____
Student Signature (If 18 years or older): _____

PART II - REFUSAL TO CONSENT
(Complete only if action described above is refused)

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:

_____
_____

Signature of Parent/Guardian: _____ Date: _____
Address: _____
Student Signature (If 18 years or older): _____

Student Health History

Student's Last Name: _____ First: _____ Middle _____

Circle One: Male or Female Birth Date: _____

Family History – (please list child's brothers and sisters)

	Name	Birth Date	Sex		Name	Birth Date	Sex
1				4			
2				5			
3				6			

Allergies (please list and describe allergies or reactions)

Medications:
Foods / Plants / Animals / Other:
Recommended treatment for severe reaction:

Injuries and Illnesses (please list any severe injuries or illnesses)

Injury / Illness	Age of Child	Hospitalized ?

Additional Information

What medications are given daily?
What medications are given frequently, but not daily?
This child is usually (circle one): very active normally active rather inactive

Do you have any other comments or concerns about this child's health or development that you would like the school to be aware of ?
If yes, please explain briefly._____

_____

Health Conditions (please check any that this child has had):

- ❑ Abnormal spinal curvature
- ❑ Allergy (Environmental)
- ❑ Allergy (food)
- ❑ Allergy (seasonal)
- ❑ Anemia
- ❑ Asthma or wheezing
- ❑ Behavior/emotional
- ❑ Birth/Congenital – Malformation
- ❑ Bleeding Disorder
- ❑ Cancer
- ❑ Chicken Pox Date of Disease _____
- ❑ Chronic diarrhea /constipation
- ❑ Concern about relations w/siblings or friends
- ❑ Cystic fibrosis
- ❑ Diabetes
- ❑ Ear/Hearing
- ❑ Emergency Care/Trauma
- ❑ Eye/Vision
- ❑ Frequent headaches
- ❑ Frequent sore throat
- ❑ Frequent stomach discomfort
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Incontinence/ bladder
- ❑ Incontinence/Bowel
- ❑ Kidney disease
- ❑ Lactose/dairy intolerant
- ❑ Meningitis/Encephalitis
- ❑ Nervous twitches /tics
- ❑ Rheumatic fever
- ❑ Seizures or epilepsy
- ❑ Sickle cell disease
- ❑ Skeletal/joint condition
- ❑ Skin Condition
- ❑ Substance abuse(alcohol or drugs)
- ❑ Suicide attempt
- ❑ Toothaches / dental infections
- ❑ Urinary tract Infections
- ❑ Other: _____

Is this child currently receiving care through a hospital? Yes or No Name of hospital _____

Form Completed By: _____ Relationship to Child: _____

By signing below, I give permission for any and all medial information to be shared with all school personnel that may interact with my child.

Parent / Guardian Signature:_____ **Date:** _____