

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

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

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): _____

Immunization Requirements for School Year 2016/17 ONLY

VERIFICATION OF PARENT NOTIFICATION of HEALTH & IMMUNIZATION REQUIREMENTS

*Parents/Guardians are required to submit a student Health History form as part of the district enrollment process.

*The Ohio Department of Health has established minimum requirements for immunizations of pupils in the public and non-public schools. **Minimum state required immunizations for the school year of 2016-2017 are as follows:**

(Some exceptions may apply or a written explanation of discrepancy from a physician may be requested)

Preschool/CDC recommendations	Kindergarten through Grade 6	Grades 7 through 12
4 doses of DTaP or DT, or any combination	Kindergarten 4 or more doses of DTaP or DT, or any combination; If the fourth dose is given at least 6 months after the third dose and on or after the 4 th birthday, dose 5 is not required. Grade 1-6: 4 or more doses of DTaP or DT, or any combination. 3 doses of Td or a combination of Td and Tdap is the minimum acceptable for ages seven and up.	4 or more doses of DTaP or DT. 3 doses of Td or a combination of Td and Tdap is the minimum acceptable for ages seven and up. Grades 7-12: 1 dose of Tdap as booster to original series is required prior to grade entry; for students in 10 th and 11 th grades, 1 dose of Td is acceptable
3 doses of OPV, IPV or any combination	3 or more doses of IPV with final dose administered on or after the 4 th birthday and at least 6 months after the previous dose regardless of the number of prior doses; If combination of OPV and IPV was given, 4 doses are required.	3 or more doses of IPV or OPV; if third dose of either series was given prior to the 4 th birthday, a fourth dose is required; If combination of OPV and IPV was given, 4 doses are required.
3-4 doses of Hib with final dose given after age 12 months or 1 dose if initial dose is given on or after 15 months of age	None	None
1 dose of MMR given on or after the student's first birthday	2 doses of MMR where dose 1 was given on or after the student's 1 st birthday and dose 2 was given at least 28 days after dose 1	2 doses of MMR where dose 1 was given on or after the student's 1 st birthday and dose 2 was given at least 28 days after dose 1
3 doses of Hepatitis B *dose 2 is 28 days after dose 1 *dose 3 is at least 16 wks after dose 1 and at least 8 wks after dose 2 *final dose is after 24 wks of age	3 doses of Hepatitis B *dose 2 is 28 days after dose 1 *dose 3 is at least 16 wks after dose 1 and at least 8 wks after dose 2 *final dose is at or after 24 weeks of age	3 doses of Hepatitis B *dose 2 is 28 days after dose 1 *dose 3 is at least 16 wks after dose 1 and at least 8 wks after dose 2 *final dose is at or after 24 weeks of age
1 dose of Varicella administered on or after the first birthday	2 doses of Varicella where dose 1 was given on or after the student's first birthday and dose 2 was given preferably at least 3 months after dose 1 but a minimum of 28 days after dose 1.	Grades 7-10: 1 dose of varicella on or after the first birthday Grades 10-12: no varicella requirement
None	None	Grade 7: 1 dose of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to entry Grade 12: Two (2) doses of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to entry. Recommended interval of at least 8 weeks between dose 1 and dose 2. If dose 1 is administered after 16 th birthday, dose 2 is not required.

NOTE: If student is required to have both MMR and Varicella vaccines and doses are not given on the same day, the vaccines must then be separated by 28 days.

Student's Name: _____ Date of Birth: _____ Date of Entrance: _____

Please sign below after reading the following statement:

I HAVE BEEN INFORMED OF THE ABOVE REQUIREMENTS FOR SCHOOL ENROLLMENT REGARDING MY CHILD'S IMMUNIZATION STATUS. I UNDERSTAND THAT A WRITTEN IMMUNIZATION RECORD MUST BE SUBMITTED AS PART OF THE ENROLLMENT PROCESS IN ORDER FOR MY CHILD TO ATTEND SCHOOL AND THAT ANY DEFICIENCY IN REQUIRED IMMUNIZATIONS MUST BE COMPLETED WITHIN 14 CALENDAR DAYS OF THE DATE OF ENTRANCE, AS NOTED. IF NOT, HE/SHE WILL BE EXCLUDED FROM SCHOOL UNTIL ALL ITEMS ARE SATISFACTORILY COMPLETED.

Parent/Guardian's Signature _____ Date _____

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):

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