



STUDENT REGISTRATION FORM

STUDENT INFORMATION

Last Name _____ First _____ Middle _____ Grade _____

Home Address _____

Home Phone _____

Date of Birth _____ Town of Birth _____ Gender _____

Student Lives with: _____

Military Status: (circle one if applicable): Active duty in Armed Forces Full time National Guard

Student has parent or legal guardians in both

CONTACT INFORMATION

Parent /Legal Guardian #1 _____ Home Phone _____

Address _____ Cell Phone _____

Employer Name _____

E-mail _____ Employer Phone _____

Relationship to Student _____

Parent /Legal Guardian #2 _____ Home Phone _____

Address _____ Cell Phone _____

Employer Name _____

E-mail _____ Employer Phone _____

Relationship to Student _____

EMERGENCY CONTACTS

(Adults other than those listed above who are willing to assume temporary care of your child and who will be contacted if we are unable to contact a parent or guardian.)

1. Full Name _____ Daytime Phone _____

Relationship _____ Cell Phone _____

2. Full Name _____ Daytime Phone _____

Relationship _____ Cell Phone _____

3. Full Name _____ Daytime Phone _____

Relationship _____ Cell Phone _____

Are there any restrictions regarding dismissals, visitations or information on your child? Yes No

If yes, explain _____

If there are legal restrictions for the school to observe, i.e. custody/guardianship orders or protection orders, Strong Foundations must be provided with the appropriate legal documentation.

MEDICAL HISTORY

Does the student have?

Asthma -----	Yes	No
Seizures -----	Yes	No
Diabetes -----	Yes	No
Hearing Problem -----	Yes	No
Vision Problems -----	Yes	No

ALLERGIES

Bees -----	Yes	No
Environmental -----	Yes	No
Seasonal -----	Yes	No
Food(s) -----	Yes	No
Medication(s) -----	Yes	No

List food(s) and/or medication(s) and type of reaction.

Does the student use? _____

IF YOU INDICATE ABOVE THAT YOUR CHILD IS IN NEED OF AN EMERGENCY MEDICATION AT SCHOOL, WE WILL REQUIRE THESE BE MADE AVAILABLE TO US WITH A PHYSICIANS ORDER **BY THE FIRST DAY OF SCHOOL**

_____	Home	School
_____	Home	School

May we have permission to use/administer?

Refresh tears lubricant eye drop	Yes	No	Children's Sudafed/decongestant	Yes	No
Tylenol (pain or fever) -----	Yes	No	Antibiotic Ointment -----	Yes	No
Ibuprofen (pain) -----	Yes	No	Calamine Lotion -----	Yes	No
Tums (indigestion) -----	Yes	No	Antiseptic Cream -----	Yes	No
Cough Drops -----	Yes	No	Hydrocortisone Cream-----	Yes	No
Benadryl -----	Yes	No	Orajel for dental pain -----	Yes	No
Children's Cough & Cold-----	Yes	No			

WOULD YOU LIKE TO BE NOTIFIED AFTER _____ OR NOT NECESSARY _____ IF WE ADMINISTER MEDICATION AT SCHOOL?

Should Strong Foundations be aware of any other medical problems or restrictions?

PERMISSION TO PROVIDE EMERGENCY TREATMENT

I hereby grant permission to Strong Foundations to administer First Aid, Epinephrine (Epi-Pen), if necessary, and secure proper emergency treatment for my child in the event a parent or legal guardian cannot be contacted.

Parent/Legal Guardian signature

Date

PERMISSION TO CONTACT STUDENT'S DOCTOR

to confirm immunization and physical exam during the school year (August to June).

Parent/Legal Guardian signature

Date

I HAVE CONFIRMED ALL OF THE ABOVE INFORMATION CONCERNING MY CHILD AND WILL NOTIFY STRONG FOUNDATIONS CHARTER SCHOOL IMMEDIATELY OF ANY CHANGES.

Parent/Legal Guardian

Date