



STUDENT REGISTRATION FORM

STUDENT INFORMATION

Last Name _____ First _____ Middle _____ Grade _____

Home Address _____
_____ Home Phone _____

Date of Birth _____ Town of Birth _____ Gender _____

Student Lives with _____

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?

Inhaler @ school ----- Yes No
 Epi-Pen for allergic reactions ----- Yes No

Current Medications (please list)

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**

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