

STERLING ELEMENTARY SCHOOL STUDENT NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT REGISTRATION FORM (Revised 7/2018) POWERSCHOOL\_\_\_\_\_\_\_\_\_\_ STARS\_\_\_\_\_\_\_\_\_\_ ELECTRONIC\_\_\_\_\_\_\_\_\_\_

FOR OFFICE USE ONLY

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| Student’s Legal Last Name | First Name | Middle Name/Initial | Preferred Name |
| Student’s Home Address |  | City | State & Zip code |
| Date of Birth | Grade | Gender  Male \_\_\_\_ Female \_\_\_\_ | Home Phone No. |
| Has this student ever been suspended? Yes \_\_\_ No \_\_\_ | | Has this student ever been expelled? Yes \_\_\_ No \_\_\_ | |
| Has this student previously attended Sterling Public School? Yes \_\_\_\_ No \_\_\_\_ | | | |
| **Ethnic Category**: Is this child Hispanic/Latino? Yes \_\_\_\_ No \_\_\_\_  Please choose all that apply to child’s race: \_\_\_ African American \_\_\_ American Indian/Alaskan Native \_\_\_ Asian  \_\_\_ Caucasian/White \_\_\_ Native Hawaiian/Other Pacific Islander | | | |
| **Medical/Emergency Information** | | | |
| In the case of a medical emergency and I cannot be reached, I give my child’s doctor or any attending physician permission to administer medical treatment. Yes \_\_\_ No \_\_\_ | | Physician’s Name | Physician’s Phone No. |
| Sterling Public School may give my child’s Medicaid number to health care providers so that the providers can bill Medicaid for services they provide my child.  Medicaid No. | | \_\_\_\_Do not share my child’s Medicaid number with the school.  \_\_\_\_Does not apply – my child is covered by insurance.  \_\_\_\_\_My child is not currently covered by any insurance. | |
| **Health Information (Check ALL that apply)**  **\_\_\_ No known health problems \_\_\_** Contacts/Glasses \_\_\_ Hearing Aids  \_\_\_ Ear Tubes \_\_\_ Frequent Ear Infections \_\_\_ Wheelchair  \_\_\_ Life threatening allergies (list) \_\_\_\_\_\_ Allergies (list) \_\_\_\_\_\_\_ Student requires Epi-pen at school? Yes \_\_\_ No \_\_\_ Student requires rescue inhaler at school? Yes \_\_\_ No \_\_\_  Asthma (\_\_\_Inhaler Dependent) \_\_\_Diabetic (\_\_\_Insulin Dependent) \_\_\_Seizure/Epilepsy (\_\_\_Medication Required) Student needs to take medication at school? Yes \_\_\_ No \_\_\_  Student has a medical condition school should be aware of? Yes \_\_\_ No \_\_\_ (Please list) | | | |
| **Special Programs** | | | |
| Does this student have a current Individual Education Plan (IEP) through Special Education? Yes \_\_\_ No \_\_\_  If yes, please indicate primary disability Does this student have a 504 Accommodation Plan (for such things as diabetes management, ADHD, etc)? Yes \_\_\_ No \_\_\_  Did this student participate in a Gifted and Talented Program at their last school? Yes \_\_\_ No \_\_\_  Home Language (please indicate) \_\_\_\_English Other: | | | |
| **Emergency Contacts – additional to parent/guardian** | | | |
| Contact #1 (Last, First Name) | | Relationship to Child | Contact Phone No. |
| Contact #2 (Last, First Name) | | Relationship to Child | Contact Phone No. |
| Contact #3 (Last, First Name) | | Relationship to Child | Contact Phone No. |
| **I hereby certify that all the information contained in this form is true and accurate to the best of my knowledge.**  My relationship to the student is: \_\_\_Parent \_\_\_Legal Guardian (Documentation Needed)  \_\_\_Person having lawful Court Order (Order Needed) \_\_\_Other  Printed Name: | | | |
| Signature | | Date | |