

# Muscogee County School District - School Information Form

School Name \_\_\_\_\_

Grade \_\_\_\_\_

## STUDENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Race: Hispanic/Latino Yes \_\_\_\_\_ No \_\_\_\_\_ *In the next line, check all options that apply.*

White \_\_\_\_\_ Black/African-American \_\_\_\_\_ Asian \_\_\_\_\_ American Indian/Alaska Native \_\_\_\_\_ Native Hawaiian/Other Pacific Islander \_\_\_\_\_

If Not Born in the USA: Country of Birth \_\_\_\_\_ Date First Enrolled in School in the USA (DD/MM/YYYY) \_\_\_\_\_

School Last Attended: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Has student ever attended a Columbus school? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, give year and name of school. \_\_\_\_\_

Has student ever been served by a Special Ed. program? Yes \_\_\_\_\_ No \_\_\_\_\_ Gifted Education? Yes \_\_\_\_\_ No \_\_\_\_\_

Does the student have a current IEP? Yes \_\_\_\_\_ No \_\_\_\_\_ Is the student on a 504 Plan? Yes \_\_\_\_\_ No \_\_\_\_\_

What language(s) did the student first learn to speak? \_\_\_\_\_

What languages(s) does the student speak at home? \_\_\_\_\_ What languages(s) does the student speak most often? \_\_\_\_\_

## PARENT/LEGAL GUARDIAN INFORMATION

Father/Legal Guardian \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother/Legal Guardian \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is a parent/guardian on active duty military? Yes \_\_\_\_\_ No \_\_\_\_\_ Is a parent/guardian a civilian employed at Ft. Benning? Yes \_\_\_\_\_ No \_\_\_\_\_

Is a parent /guardian a migrant worker? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Person with Whom Student Lives \_\_\_\_\_

Relationship to Student: Parent \_\_\_\_\_ Legal Guardian \_\_\_\_\_ Foster Parent \_\_\_\_\_ Relative \_\_\_\_\_ Friend \_\_\_\_\_ Other (Specify.) \_\_\_\_\_

## EMERGENCY CONTACT \*\*\*Please indicate an individual other than registering person.\*\*\*

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Relationship \_\_\_\_\_

## STUDENT MAY BE CHECKED OUT BY THE FOLLOWING PEOPLE. \*\*\*Please indicate individuals other than registering person.\*\*\*

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Relationship \_\_\_\_\_

## TRANSPORTATION – Check all that apply.

Bus (Include bus #.) \_\_\_\_\_ Car rider \_\_\_\_\_ Student Driver \_\_\_\_\_ Walker \_\_\_\_\_ Before School Program \_\_\_\_\_ After School Program \_\_\_\_\_

Day Care (Include name of Day Care Provider.) \_\_\_\_\_ Day Care Phone \_\_\_\_\_

**FIELD TRIP PARENTAL AUTHORIZATION**

(Name of student) \_\_\_\_\_ has my permission to attend all field trips scheduled for the assigned school during this school year. If for any reason I do NOT want him/her to attend a particular field trip, I will notify the school.

**SIBLING INFORMATION (Brothers and sisters 18 years of age or under)**

Name \_\_\_\_\_ Birthdate (MM/DD/YYYY) \_\_\_\_\_ School Attending or Reason If Not in School \_\_\_\_\_

Name \_\_\_\_\_ Birthdate (MM/DD/YYYY) \_\_\_\_\_ School Attending or Reason If Not in School \_\_\_\_\_

Name \_\_\_\_\_ Birthdate (MM/DD/YYYY) \_\_\_\_\_ School Attending or Reason If Not in School \_\_\_\_\_

Name \_\_\_\_\_ Birthdate (MM/DD/YYYY) \_\_\_\_\_ School Attending or Reason If Not in School \_\_\_\_\_

**STUDENT HEALTH RECORD**

Drug Allergy (Name) \_\_\_\_\_ Severe? Yes No Food Allergy (Type) \_\_\_\_\_ Severe? Yes No

Insect Allergy (Type) \_\_\_\_\_ Severe? Yes No Other Allergies \_\_\_\_\_ Severe? Yes No

Does student use auto-injectable epinephrine? (Epi-Pen or Twin-ject) Yes No

ADD/ADHD (Medication?) \_\_\_\_\_

Asthma (Rescue inhaler?) Yes No

Diabetes Type 1 Type 2 Meds: \_\_\_\_\_

Epilepsy/Seizure \_\_\_\_\_

Heart Condition \_\_\_\_\_

Kidney Problem \_\_\_\_\_

Sickle Cell Disease \_\_\_\_\_

Glasses Braces Hearing Aid

Prosthesis \_\_\_\_\_

Physical Restriction (Type) \_\_\_\_\_

Does student have a disability? Yes No

Does student require medication routinely? Yes No

List ALL medications student is presently taking. \_\_\_\_\_

Reason for Medication(s) \_\_\_\_\_

Has student been hospitalized in the past five years? Yes No

If Yes, explain below.

Is there a medical reason which prohibits the student's participation in physical education? Yes No *If yes, please supply a doctor's statement for school files.*

Name of Family Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

Does the school have permission to screen the student's vision and hearing as part of his/her educational evaluation? Yes No

May the Registered Nurse/Clinic Worker contact your child's physician regarding the student's health care needs if necessary? Yes No

In the event of an emergency, does a representative of the school have your permission to call the doctor listed above if the parent/legal guardian cannot be reached? Yes No

In the event of an emergency, does a representative of the school have permission to call an ambulance to transport the student to the hospital if the parent/legal guardian cannot be reached? Yes No *If yes, specify the hospital you would like your child to be transported to.*

Martin Army Hospital Doctors Hospital Medical Center St. Francis Other (Specify.) \_\_\_\_\_

Optional Question: Does your child have health insurance coverage (ex: Medicaid, Peachcare, Tri-Care, Blue Cross, etc.)? Yes No

Signature of Parent/Legal Guardian \_\_\_\_\_

Date Submitted \_\_\_\_\_

<i>Office Use Only</i>	
SCHOOL YEAR	_____
SS#	Birth Certificate
Immunization	Proof of Residency
EED	