

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 _____

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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 _____

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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	