

REGISTRATION FORM

TRI COUNTY AREA SCHOOLS

Student Name _____

Last First Middle

Birth Date _____ **Birthplace** _____

City/State

Phone Number _____ Listed: Yes No

Physical Address: _____

Number/Street City Zip

Mailing Address: _____

PO Box City Zip

County _____ **Township** _____

Check here if this address is temporary

Gender: Male Female

Entering Grade _____

Has your child ever attended Tri County before? Y N

Language spoken in home _____

Ethnic Codes _____

Use 1,2,3 to rank primary and secondary ethnic groups

- 1** Native Am. **2** Caucasian **3** Hispanic **4** African-American
5 Asian Am. **6** Middle Eastern **7** Multi-Ethnic/Other

For Kindergarten students only: Check any that child has previously done.

- | | |
|--|---|
| <input type="checkbox"/> No previous social group (0) | <input type="checkbox"/> Head Start (2) |
| <input type="checkbox"/> Full day kindergarten (7) | <input type="checkbox"/> Preschool experience (3) |
| <input type="checkbox"/> Half day kindergarten (6) | <input type="checkbox"/> Daycare setting (4) |
| <input type="checkbox"/> Church activity/Sunday school (1) | |

First DPT Shot Date _____

Adult MALE Residing in the Home _____

Name

Work Phone _____

*Parent Education Level (see below) _____

Adult FEMALE Residing in the Home _____

Name

Work Phone _____

*Parent Education Level (see below) _____

Parent Education Level

- 1 – completed grade 8 or less
2 – some high school
3 – high school graduate
4 – post high school

Schools Attended with Addresses (Most recent first)

DO NOT FILL OUT OR MARK

OFFICE USE ONLY

Student Number _____

Entry Date _____

Entry Code _____ Prev. LEA _____

Birth Certificate: Y N YOG _____

Street Code # _____

Teacher Name/# _____

Rm# _____ Next School _____

School of Choice: Yes No

Home School/# _____

Bus #: _____

Immunization Records: Yes No

Lunch Application: Yes No

Student Records:

Requested: _____

Received: _____

NON-RESIDENT STATUS:

Dual Residency _____

Schools-of-Choice _____

District Release _____

Child Lives With: (circle one)

B – both parents

C – father/stepmother

D – mother/stepfather

E – father only

F – mother only

G – legal guardian

H – court placed _____

J – relative _____

K – foster home _____

L – divorced, joint custody

OVER →

Special Services your student received at previous school (circle all that apply).

Speech Social Worker Title I Counseling 504 Plan Special Education _____

Emergency Contact Person _____ Relationship _____

Phone Number _____

Emergency Contact Person _____ Relationship _____

Phone Number _____

Emergency Medical Conditions/Problems: Indicate **ALL** that apply _____

- nothing known (1)
- iodine allergy (9)
- wears glasses (17)
- medical waiver (2)
- multiple allergy (10)
- bee sting (18)
- rheumatic (3)
- epileptic (11)
- asthma (19)
- cardiac (4)
- contact lenses (12)
- nose bleeds (20)
- hemophiliac (5)
- special blood condition(13)
- no medication-religious (21)
- diabetic (6)
- sulfa allergy (14)
- check health card (22)
- aspirin allergy (7)
- muscle weakness (15)
- attention deficit disorder(23)
- penicillin allergy (8)
- headaches (16)
- hearing problems (24)

*Takes medication regularly (please indicate which medication and how often)

Other children who reside in the home:

<u>Name</u>	<u>Birth date</u>	<u>Grade</u>		
_____	_____	_____	natural sibling	step sibling
_____	_____	_____	natural sibling	step sibling
_____	_____	_____	natural sibling	step sibling
_____	_____	_____	natural sibling	step sibling
_____	_____	_____	natural sibling	step sibling

Does your child attend a daycare center or go to a sitter after school? Yes No

If yes: Name _____ Phone # _____

Address _____

Parent/Guardian email: _____

I affirm, that as the parent/legal guardian, all information provided above is true and accurate, and that my child and I reside at the listed address. I understand any false information provided by me may subject me to legal penalties for perjury.

Parent/Guardian/Custodial Parent

Date