



WOONSOCKET EDUCATION DEPARTMENT
CONFIDENTIAL / EMERGENCY / REGISTRATION FORM
 NEW _____ Re-enrolled _____ Registration Date _____
REGISTRATION NO. _____
Date of Admittance _____

_____ **Print Last Name of Child** _____ **First Name** _____ **Middle Initial** _____
 _____ **Address** _____ **Apt.#** _____ **P.O. Box** _____
 _____ **Tel. Number** *Unlisted* _____ **Cell Phone** _____ **Email Address** _____

_____ **Sex** _____ **Student Social Security No.** _____ **Date of Birth** _____ **Place of Birth** _____ **Grade Entering** _____

Are you Hispanic or Latino? (choose only one) _____ YES (code D) _____ NO

Y j cvku" { qwt tcegA*ej qqug"qpg+" "" aaaaAmerican Indian"qt"Alaska P cvkxg (A) "" "" aaaaAsian (B) "" "" aaaaBlack"qt"Chrlcep"Co gtlecp (C) "" "" aaaaY j kg*G+ "" "" aaaaP cvkxg"J cy cklep"qt"Rcehhe"Krcpfgt*H" "" "" aaaaVy q"qt"O qtg" Tcegu*Q+
Primary Language spoken at home: _____ "Ncu" I tcf g'Ego rnygf "O qvj gt -aaaaaaa" Hcvj gt -aaaaaaa

"Full Name of Parent(s) / Guardian(s)	Relationship (List mother's maiden name here) & Date of Birth	Marital Status (married/divorced/separated)	Emergency "Contact # "	"Occupation "	Parent/Guardian's Place of Employment	Work Telephone No.
	D.O.B. _____ Mother					
	D.O.B. _____ Father					

Pupil lives with: _____ **Relationship:** _____

PLEASE LIST THE FULL NAMES OF ALL THE STUDENT'S BROTHERS AND SISTERS

Last Name	First Name	Relationship	Age	Place s/he attends school

Please name any other individuals living with family.

THE FOLLOWING MUST BE FILLED OUT:

List 2 neighbors, relatives, or friends with access to transportation who will assume temporary care of your child if you cannot be reached.

Name _____ **Address** _____ **Tel. No.** _____ **Relationship** _____
Name _____ **Address** _____ **Tel. No.** _____ **Relationship** _____

Has your child ever attended Woonsocket Schools? No Yes **School Name & Grade(s):** _____
Has the student ever attended ANY Rhode Island School? No Yes **School Name & Grade(s):** _____
Last School Attended: _____ **Grade:** _____ **Address:** _____ **Telephone:** _____ **Date Left:** _____

IF APPLICABLE WHICH GRADE(S) DID YOU REPEAT

Where you receiving special services? (check all that apply) Self contained Special Ed. Resource Adaptive Physical Ed. Counseling
 Individual Ed. Plan (IEP) ESL

NOTE: Please be sure to complete the back side of this form.

CONFIDENTIAL HEALTH INFORMATION

If you answer yes to any of the questions listed below, please explain further:

If your child has any condition which calls for special care or restricted activity, please note it here.

Does your child have any allergies? (food, medications, bee stings, pollen, etc.) No Yes Explain: _____

Has your child ever needed medication or medical attention in the past for an allergic reaction? No Yes Explain: _____

Does your child have asthma? (If Yes) What year was he/she diagnosed? No Yes Explain: _____

Has your child ever been hospitalized for a serious illness or injury? No Yes Explain: _____

Does your child have any physical condition of which the school should be aware? No Yes Explain: _____

Does your child have a hearing problem? No Yes Explain: _____

Does your child wear glasses/contacts? No Yes Explain: _____

Is your child on any medication? No Yes *What is the name of the medication(s) and reason for taking it?*

Name of medication(s) _____ Reason for medication(s) _____

Name of medication(s) _____ Reason for medication(s) _____

ALL MEDICATION TO BE GIVEN IN SCHOOL MUST HAVE A DOCTOR'S WRITTEN ORDER AND BE IN A LABELED PHARMACY CONTAINER.

School health programs state that students must present evidence of immunization at school entry. If a student cannot present acceptable evidence of immunization at entry he/she must be excluded.

Please indicate with a check mark if this child has any of the following health problems

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> BONE OR JOINT DISEASE | <input type="checkbox"/> THROAT INFECTIONS (FREQUENT) | <input type="checkbox"/> CHICKEN POX (YEAR _____) | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> CONVULSIONS/SEIZURES | <input type="checkbox"/> DENTAL PROBLEMS | <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> ECZEMA |
| <input type="checkbox"/> MENSTRUAL PROBLEMS | <input type="checkbox"/> HEADACHES (FREQUENT) | <input type="checkbox"/> HEART PROBLEMS/MURMURS | <input type="checkbox"/> KIDNEY PROBLEMS |

Any other health problem? (Please Explain) _____

In the event of an accident or serious illness, I hereby authorize the school to contact the physician indicated below and to follow his/her instructions, if the school is unable to reach me. If it is impossible to contact the physician, or if the problem needs immediate attention, the school may make whatever arrangement they deem necessary for the well being of my child. If this information changes during the school year, please contact the child's school.

Local Physician's Name _____ Address _____ Telephone _____

Local Dentist's Name _____ Address _____ Telephone _____

PARENT/GUARDIAN'S SIGNATURE _____ **Date** _____

ADMINISTRATIVE USE ONLY

Nurse's Approval _____ Medicare No. (if any) _____ Counselor _____

Teacher's Name _____ Grade _____ Room No. _____ Student ID No. _____ Year of Graduation _____