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

What is your race? (choose one) ____American Indian or Alaska Native (A) ____Asian (B) ___Black or African American (C) ___White(E) ___Native Hawaiian or Pacific Islander(F) ___Two or More Races (O)

Primary Language spoken at home: ____________________ **Last Grade Completed (Mother)_______ (Father)_______**

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.

Revised 4/26/2011

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

☐ BONE OR JOINT DISEASE	☐ THROAT INFECTIONS (FREQUENT)	☐ CHICKEN POX (YEAR ________)	☐ DIABETES
☐ CONVULSIONS/SEIZURES	☐ DENTAL PROBLEMS	☐ EAR INFECTIONS	☐ ECZEMA
☐ MENSTRUAL PROBLEMS	☐ HEADACHES (FREQUENT)	☐ HEART PROBLEMS/MURMURS	☐ 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 ____________