

CUMBERLAND PUBLIC SCHOOLS

NEW STUDENT REGISTRATION FORM

Rev. Jan. 12, 2010

THIS SECTION FOR OFFICE USE ONLY

REGISTRATION DATE ___/___/___ TIME _____ a.m./p.m.		START DATE ___/___/___ GRADE _____ Session: AM/PM	
IDENTIFICATION		PROOF OF RESIDENCY	
<input type="checkbox"/> Birth Certificate (Original) <input type="checkbox"/> Passport <input type="checkbox"/> DCYF Intrastate ID Card (also serves as proof of residency).		<input type="checkbox"/> Purchase and sales agreement <input type="checkbox"/> Property/fire tax or water bill <input type="checkbox"/> Lease or Rental Agreement <input type="checkbox"/> Rent receipt <input type="checkbox"/> Residency affidavit <input type="checkbox"/> Bank closing Settlement Sheet <input type="checkbox"/> DCYF Intrastate ID Card	
IMMUNIZATIONS		PLACEMENT	
Checked by _____ Checked on ___/___/___ <input type="checkbox"/> Complete <input type="checkbox"/> DCYF		Neighborhood school _____ Spec. Ed. placement _____ Out-of-district _____ <input type="checkbox"/> ESL (check if required)	
		SMX	
		<input type="checkbox"/> Registration <input type="checkbox"/> Enrollment <input type="checkbox"/> <ST210> Neighborhood/ assigned school noted in Comments (out of district only) <input type="checkbox"/> Contacts entered <input type="checkbox"/> "New Student" email sent	
		Confirmed with _____ Registered by: _____	

PLEASE PRINT and COMPLETE EACH SECTION.

Step 1: Family Information

<ce405> SMX DWLL# _____ <ce415> SMX FAM# _____

1. Parent/Guardian **Father** **Mother**

Name _____ **EMAIL ADDRESS** _____
(Last) (First) (Middle)

Address (if different from student)

(Street) (Apt #) (Town) (ST) (ZIP)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

2. Parent/Guardian **Father** **Mother**

Name _____ **EMAIL ADDRESS** _____
(Last) (First) (Middle)

Address (if different from student)

(Street) (Apt #) (Town) (ST) (ZIP)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Step 2: Student Information

<ce220> SMX SID # _____

Male Female Date of Birth ___/___/___ Grade _____

Student Name _____
(Last) (First) (Middle)

Address _____
(Street) (Apt or Unit #) (Town) (ST) (ZIP)

School Last Attended _____
(Name of School) (Town) (ST) (ZIP) (PHONE #)

New Federal standards require that school districts collect and report information regarding race and ethnicity.

Is your child Hispanic or Latino? Yes _____ No _____

What is your child's race? American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

I certify that the information I've provided in this document is accurate, and that the child named above will be permanently residing at the indicated address. It is my responsibility to notify the school of any change of information.

Parent/Legal Guardian Signature _____ **Date** _____

Student's Name _____ Date of Birth _____ GR. _____

Step 3: Specialized Services Section

- Does your child presently have an Individualized Education Plan (IEP)? Yes No
- Are you providing a copy of your child's IEP? Yes No
- Has your child had a screening test with Child Outreach? Yes No
- Does your child have a 504 plan? Yes No
- Does your child presently receive any English as a Second Language instruction? Yes No
- Does your child receive any other services not already mentioned? If yes, please explain: Yes No

Step 4: Emergency Contacts & Release Procedures <st415> CONTACTS ENTERED IN SMX _____

In the event of a major illness or injury, 911 will be called first. If you are unavailable, we will contact the individuals below in the order listed in the event of an illness or emergency involving your child. The people listed should be available during school hours. Your child may also be released to these individuals under other circumstances at your request or the school's request. Suitable identification (driver's license) will be necessary before the child is released. These are the only people authorized to pick up your child from school. Please complete this section as accurately as possible.

I, _____ (parent/guardian name) authorize the school to release my child to the individuals named below:

<u>Name</u>	<u>Relationship to Child</u>	<u>Daytime Phone</u> <i>Indicate if Home, Work, or Cell Number</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Step 5: Permission to Photograph/Video Tape Your Child

We are proud of our students and the special events that take place at our schools. Occasionally throughout the year we invite the press to report on our events. CHECK THE BOX BELOW IF YOU DO NOT GIVE PERMISSION FOR YOUR CHILD TO BE PHOTOGRAPHED OR VIDEOTAPED. **If we have your permission to photograph your child, you need to do nothing.**

I **do not** give my consent allowing my child to be photographed or video taped at school events and published in media and on the school web site.

Parent/Guardian Signature _____ Date: _____

Student's Name _____ Date of Birth _____ GR. _____

Step 6: Home Language Survey

PLEASE COMPLETE THIS FORM **WHETHER OR NOT** YOU SPEAK A LANGUAGE OTHER THAN ENGLISH.

HOME LANGUAGE SURVEY

Perguntas sobre a lingua que e mais usada em casa

Preguntas sobre el idioma usado en la casa

1a. WHAT LANGUAGE DID YOUR CHILD LEARN FIRST TO SPEAK? _____

1b. Qual foi a primeira lingua que o seu filho/a aprendeu a falar? _____

1c. Cual fue el primer idioma que su hijo/a aprendio a hablar? _____

2a. WHAT LANGUAGE DO YOU USE MOST WHEN SPEAKING TO YOUR CHILD? _____

2b. Qual e a lingua que usa com mais frecuencia quando fala com os seus filhos? _____

2c. Cual es el idioma que usa con mas frecuencia cuando habla con sus hijos? _____

3a. WHAT LANGUAGE DOES YOUR CHILD SPEAK MOSTLY WHEN SPEAKING TO YOU? _____

3b. Qual e a lingua que o seu filho usa com mais frecuencia quando fala consigo? _____

3c. Cual es el idioma que su hijo habla mas frecuentemente cuando habla con Ud.? _____

4a. WHAT LANGUAGE DOES YOUR CHILD USE MOSTLY WHEN SPEAKING TO OTHER ADULTS? _____

4b. Que lingua usa o seu filho com mais frecuencia quando fala com outros adultos? _____

4c. Cual es el idioma que su hijo usa con mas frecuencia cuando habla con otros adultos? _____

5a. WHAT LANGUAGE DOES HE/SHE USE WHEN SPEAKING TO SIBLINGS AND FRIENDS? _____

5b. Que lingua usa o seu filho para falar com os irmaos e amigos? _____

5c. Cual es el idioma que su hijo habla con los hermanos y amigos? _____

6a. IF YOUR CHILD WAS NOT BORN IN THE UNITED STATES, IN WHAT COUNTRY WAS HE/SHE BORN? _____ What year did he/she enter this country? _____

6b. SI SU NIÑO NO NACIÓ EN LOS ESTADOS UNIDOS, EN QUÉ PAÍS NACIÓ ÉLELLA ? _____
 En qué año entró él/ella en este país? _____

6c. SE SUA CRIANÇA NÃO NASCEU NOS ESTADOS UNIDOS, EM QUE PAÍS NASCEAU? _____
 Em que ano entrou neste país? _____

Student's Name _____ **Date of Birth** _____ **GR.** _____

Step 7: Student Health Section

Physician's Name _____ Phone: _____

IF YOU ANSWER YES TO ANY QUESTION, PLEASE EXPLAIN

1. Has your child ever had any operations or serious illnesses? If yes, please explain. Yes No

2. Has your child had any serious accidents? If yes, please explain. Yes No

3. Does your child wear eyeglasses, contacts, braces, hearing aids, or any other corrective device? _____ Yes No
4. Has your child had the following (Give month, year and/or age if known):

Chicken Pox _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart condition _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Nosebleeds _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent sore throats _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	High fevers _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Infections _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Eye condition _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Other (please specify) _____
5. Has your child had a neurological evaluation? If yes, when? _____ Yes No
6. Has your child had a psychological evaluation? If yes, when? _____ Yes No
7. Is your child restricted from physical activities? If yes, please explain. Yes No

8. Is your child allergic to: medicines/drugs? If yes, please specify. Yes No

Is your child allergic to: plants/foods? If yes, please specify. Yes No

Is your child allergic to: insect stings? If yes, please specify. Yes No

9. If you answered yes to question #8, does your child take medicine for this allergy? Yes No
If yes, please specify. (i.e. Benadryl, Epi-Pen, etc.) _____
10. Does your child have asthma? If yes, date diagnosed: _____ Yes No
If yes, what medication(s) does he/she take: _____

11. Does your child take any daily medications? If yes, please specify. _____ Yes No
12. Will medications be given at school? _____ Yes No
13. What medications are given frequently, but not daily _____
14. Would you like a conference with the school nurse? _____ Yes No

Parent Name: (Please Print) _____

PARENT SIGNATURE: _____ **DATE:** _____