

# CUMBERLAND SCHOOL DEPARTMENT

## STUDENT REGISTRATION FORM

Rev. January 10, 2019

**THIS SECTION FOR OFFICE USE ONLY**

REGISTRATION DATE \_\_\_/\_\_\_/\_\_\_ TIME \_\_\_\_\_ a.m./p.m. START DATE \_\_\_/\_\_\_/\_\_\_ GRADE \_\_\_\_\_ Session: AM/PM

**IDENTIFICATION**

- Birth Certificate (Original)
- Passport
- DCYF Intrastate ID Card (also serves as proof of residency).

**IMMUNIZATIONS**

- Checked by \_\_\_\_\_  
 Checked on \_\_\_/\_\_\_/\_\_\_  
 Complete  
 DCYF

**PROOF OF RESIDENCY**

- Purchase and sales agreement
- Property/fire tax or water bill
- Lease or Rental Agreement
- Rent receipt
- Residency affidavit
- Bank Closing Settlement Sheet
- DCYF Intrastate ID Card
- Piece of mail to address

**PLACEMENT**

- Neighborhood school \_\_\_\_\_  
 Spec. Ed. placement \_\_\_\_\_  
 Out-of-district \_\_\_\_\_  
 ESL (check if required)  
 Confirmed with \_\_\_\_\_

- Registration
  - Enrollment
  - Neighborhood/ assigned school noted in Comments (out of district only)
  - Contacts entered
  - "New Student" email sent
- Registered by: \_\_\_\_\_

**PLEASE PRINT and COMPLETE EACH SECTION**

**Step 1: Student Information**

(Aspen ID # \_\_\_\_\_)

Male  Female Date of Birth: (Month) \_\_\_/(Day) \_\_\_/(Year) \_\_\_ Grade \_\_\_\_\_

Student Name \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_  
(Street) (Apt or Unit #) (Town/State) (ZIP)

School Last Attended \_\_\_\_\_  
(Name of School) (Town/State) (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

If your child is Southeast Asian, please check their country of origin or ethnic group: \_\_\_ Brunei \_\_\_ Burma (Myanmar) \_\_\_ Cambodia \_\_\_ Philippines \_\_\_ Hmong \_\_\_ Indonesia \_\_\_ Laos \_\_\_ Malaysia \_\_\_ Thailand \_\_\_ Timor-Leste \_\_\_ Singapore \_\_\_ Vietnam

Has your child ever been registered and/or enrolled in the Cumberland Public Schools? No \_\_\_ Yes \_\_\_

Do you have other children attending Cumberland Public Schools? No \_\_\_ Yes \_\_\_ Name of Child(ren) \_\_\_\_\_

Is the parent a member of the Armed Forces on active duty, which includes a parent on full time National Guard duty? No \_\_\_ Yes \_\_\_

**Step 2: Family Information**

**1. Parent/Guardian**  Father  Mother

Name \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
(Last) (First) (Middle)

Address (if different from student) \_\_\_\_\_  
(Street) (Apt #) (Town / State) (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/ State) (ZIP)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**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**

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**

The information requested on this form is necessary for the most appropriate placement for your child as required by Rhode Island Law (R.I.G.L. §16-54-2) and the Equal Educational Opportunity Act (20 U.S.C. §1703(f)) and will not be used for any other purposes. Thank you for your cooperation.

To be completed by parent or guardian:

Student Name: \_\_\_\_\_

Registration  
Date: \_\_\_\_\_

Date of  
Birth: \_\_\_\_\_

1.\* WHAT IS THE PRIMARY LANGUAGE MOST OFTEN USED IN THE HOME, REGARDLESS OF THE LANGUAGE SPOKEN BY YOUR CHILD? \_\_\_\_\_

2.\* WHAT IS THE LANGUAGE THAT YOUR CHILD FIRST ACQUIRED? \_\_\_\_\_

3.\* WHAT IS THE LANGUAGE MOST OFTEN SPOKEN BY YOUR CHILD? \_\_\_\_\_

4. WHAT LANGUAGE DOES YOUR CHILD USE MOST OFTEN WHEN SPEAKING TO OTHER ADULTS IN THE HOME OR TO THEIR PRIMARY CARETAKER? \_\_\_\_\_

5. WHAT LANGUAGE DOES YOUR CHILD USE MOST OFTEN WHEN SPEAKING TO SIBLINGS OR OTHER CHILDREN IN THE HOME? \_\_\_\_\_

6. WHAT LANGUAGE DOES YOUR CHILD USE MOST OFTEN WHEN SPEAKING TO friends or neighbors outside the home? \_\_\_\_\_

7. IN WHAT LANGUAGE WOULD YOU PREFER TO RECEIVE INFORMATION FROM THE SCHOOL? \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Parent/Guardian Name

**\*NOTE:** If a parent or guardian responds 'yes' to the first three questions, a language screening assessment should be administered regardless of the additional information provided.

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 \_\_\_\_\_  Yes  No Heart condition \_\_\_\_\_  Yes  No

Pneumonia \_\_\_\_\_  Yes  No Diabetes \_\_\_\_\_  Yes  No

Nosebleeds \_\_\_\_\_  Yes  No Seizures \_\_\_\_\_  Yes  No

Frequent sore throats \_\_\_\_\_  Yes  No High fevers \_\_\_\_\_  Yes  No

Ear Infections \_\_\_\_\_  Yes  No Migraines \_\_\_\_\_  Yes  No

Eye condition \_\_\_\_\_  Yes  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: \_\_\_\_\_