

Student Registration Form – Emergency Authorization & Medical Information Form

Name (Last) (First) (Middle Name) Grade Gender M or F

Address

City Zip Code Telephone

County of Residence (Check One) Calumet Fond du Lac Sheboygan

Date of Birth (Month) (Day) (Year) Place of Birth (City, County, State, Country)

Year first attended United States school if place of birth is country outside of the United States

Parent/Guardian E-mail Address: Home Work

If different than New Holstein: School Last Attended

Name City, State

Is this student Hispanic or Latino (Must check one)? No, not Hispanic or Latino Yes, Hispanic or Latino

Is this student (Check one or more. You must select at least one.)

American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Other Pacific Islander White

Father/Guardian (Last) (First) (Middle) (Mr., Dr., Etc.)

If different than student: Address

City Zip Code Cell phone

Employer Occupation

Work Address City:

Work Phone Ext.: Work Hours From To

Mother/Guardian (Last) (First) (Middle) (Mrs., Ms., Dr., Etc.)

If different than student: Address

City Zip Code Cell phone

Employer Occupation

Work Address City:

Work Phone Ext.: Work Hours From To

Parents Marital Status Child Resides With

If Separated or Divorced, Name of Parent with Legal Custody:

Does the other Parent have Visitation Rights? Yes No Does this Parent want Access to School Mailings, etc. Yes No

EMERGENCY INFORMATION

In an emergency, if neither parent can be reached, please indicate a person to provide temporary care for your child

Name _____ Address _____

Telephone (____) _____ Relationship to your child _____

Family Physician _____ Phone (____) _____

Dentist _____ Phone (____) _____

Parent/Guardian Insurance Carrier _____

EMERGENCY MEDICAL AND DENTAL CARE

I hereby authorize the school principal, teacher, or nurse to call the family physician or dentist named previously if a need for emergency medical care exists and I cannot be reached immediately.

In the event that the family physician or dentist is not available and school authorities are not able to locate my designee, or me I authorize the school authorities to secure the medical services of the trained personnel and institution that are most readily available.

Parent/Guardian signature _____ Date _____

HEALTH INFORMATION: List any Medical Alert, Allergies and/or Special Instructions: _____

List any diseases, conditions, medications, special diets, or special needs that your student may have: _____

Does your student have any physical concern, or any other difficulty, which should be brought to the attention of the teacher?

_____ if so explain: _____

Has your student had any serious illness or accident in the last year? _____

PLEASE LIST NAMES OF OTHER CHILDREN IN THE FAMILY UNDER 18 YEARS OF AGE

Last Name	First	Age	School Attending	Grade	Date of Birth
Gender					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

COMPLETE IF YOUR CHILD WILL RIDE THE BUS: (even if they do not ride everyday)

The distance from our house to the school is: (check one)

- 0 through 2 miles (Including City Busing)
 Over 2 through 5 miles
 Over 5 through 8 miles
 Over 8 through 12 miles
 Over 12 miles