

TWO ROCK ELEMENTARY SCHOOL
STUDENT REGISTRATION FORM

STUDENT'S NAME				BIRTHDATE																					
LEGAL NAME _____ Last _____ First _____ Middle _____ Circle One: <input type="checkbox"/> Male <input type="checkbox"/> Female				Month _____ Day _____ Year _____ BIRTHPLACE																					
TELEPHONE _____ Student S.# _____				City _____ State _____																					
ADDRESS _____ CITY _____ ZIP _____				PREVIOUS SCHOOL																					
MAILING ADDRESS _____				Name																					
STUDENT IS LIVING WITH (CHECK) <input type="checkbox"/> father <input type="checkbox"/> mother <input type="checkbox"/> stepfather <input type="checkbox"/> stepmother <input type="checkbox"/> guardian(m) <input type="checkbox"/> guardian(f) <input type="checkbox"/> foster father <input type="checkbox"/> foster mother <input type="checkbox"/> other <input type="checkbox"/> other		STATUS OF PARENT <input type="checkbox"/> deceased <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> separated <input type="checkbox"/> other		ETHNIC GROUP <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Amer.Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Filipino <input type="checkbox"/> Pacific Islander																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 2px;">PARENT CHECKED ABOVE</td> <td style="width: 35%; padding: 2px;">OCCUPATION</td> <td style="width: 40%; padding: 2px;">BUSINESS PHONE</td> </tr> <tr> <td style="padding: 2px;">Mother</td> <td></td> <td></td> </tr> <tr> <td style="padding: 2px;">Father</td> <td></td> <td></td> </tr> <tr> <td style="padding: 2px;">Mother Birthplace</td> <td colspan="2" style="padding: 2px;">Father Birthplace</td> </tr> <tr> <td style="padding: 2px;">U.S. Citizen Yes No</td> <td colspan="2" style="padding: 2px;">U.S. Citizen Yes No</td> </tr> </table>				PARENT CHECKED ABOVE	OCCUPATION	BUSINESS PHONE	Mother			Father			Mother Birthplace	Father Birthplace		U.S. Citizen Yes No	U.S. Citizen Yes No		SCHOOL USE ONLY						
PARENT CHECKED ABOVE	OCCUPATION	BUSINESS PHONE																							
Mother																									
Father																									
Mother Birthplace	Father Birthplace																								
U.S. Citizen Yes No	U.S. Citizen Yes No																								
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 2px;">Other Children in Family</td> <td style="width: 25%; padding: 2px;">last</td> <td style="width: 25%; padding: 2px;">first</td> <td style="width: 25%; padding: 2px;">middle</td> <td style="width: 20%; padding: 2px;">birthdate</td> </tr> <tr> <td></td> <td>last</td> <td>first</td> <td>middle</td> <td>birthdate</td> </tr> <tr> <td></td> <td>last</td> <td>first</td> <td>middle</td> <td>birthdate</td> </tr> <tr> <td></td> <td>last</td> <td>first</td> <td>middle</td> <td>birthdate</td> </tr> </table>				Other Children in Family	last	first	middle	birthdate		last	first	middle	birthdate		last	first	middle	birthdate		last	first	middle	birthdate	1. Immunization _____ 2. Emergency Card _____ 3. Lunch Application _____ 4. Special Programs _____ _____ _____	
Other Children in Family	last	first	middle	birthdate																					
	last	first	middle	birthdate																					
	last	first	middle	birthdate																					
	last	first	middle	birthdate																					
HOME LANGUAGE SURVEY				BIRTH VERIFICATION																					
1. Which language did your son/daughter learn when he/she firsts began to talk? _____ 2. What language did your son/daughter most frequently use at home? _____ 3. What language do you use most frequently to speak to your son/daughter? _____ 4. Name the language most often spoken by the adults at home: _____				Evidence _____ Initials _____ Has your child been retained? What Grade? _____ Is child in special classes? _____ _____																					

PARENT LEVEL OF EDUCATION (For STAR test- State required):

Please circle one:

- 1=Not a high school graduate
- 2=High school graduate
- 3=Some college
- 4=College graduate
- 5=Graduate school/post graduate training

Assigned to grade _____ Teacher _____

Parent Signature _____

Date _____

Sonoma County Office of Education STUDENT HEALTH HISTORY

Date: _____ School: _____

Student's Name: _____ Sex: M F

Birthdate: _____ Teacher: _____

Parent/Guardian: _____

Address: _____

Street Apt. City Zip

Telephone: (Home) () _____ (Work) () _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Stinging Inset Allergy
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Convulsion, Seizure
<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Recurring Ear Infections	<input type="checkbox"/> Eye Problems
<input type="checkbox"/> Movement Limitation		
<input type="checkbox"/> Recent illness, hospitalization, surgery or other physical condition which limits your child's physical activity at school		

Please provide additional information for any of the above conditions checked:

➤ **ALL MEDICATION SENT TO SCHOOL MUST BE IN THE PRESCRIPTION CONTAINER WITH A CURRENT DATE.**

Does your child require medication while at school? Yes No

If yes, please complete an "Authorization for Administration of Medication" (obtain form from the school secretary)

Please indicate:

Medication _____	Dosage _____	Hour(s) given _____
Medication _____	Dosage _____	Hour(s) given _____

Date of last physical exam: _____ / _____ / _____ Doctor: _____

Date of last dental exam: _____ / _____ / _____ Dentist: _____

Does your child wear glasses? Yes No

Does your child have any medical condition which might require care while at school or which might restrict his/her physical activity, such as in contact sports? (Please describe)

Information obtained from this health history may be included on a confidential health conditions list, if appropriate. For more information/concerns, please contact the school nurse.

_____ PARENT SIGNATURE _____ DATE

H 5 White: CUM File Yellow: Health Office