

OFFICE USE ONLY:

Date last attended previous

school: _____

Starting Date: _____

**HOPKINS PUBLIC SCHOOLS
REGISTRATION FORM****OFFICE USE ONLY:**

Building: _____ Bus

Birth Cert. on file:

Yes No

Legal Name _____
Last First Middle Initial Phone NumberAddress _____
Number/Street City State County(residence)Place of Birth _____
City/State County Birthdate

Age at time of enrollment _____ Enrolling grade _____ Social Security _____

Gender: (circle one) M F Racial/Ethnic Background _____

Date of first DPT/DAT Immunization _____

Schools of Choice Yes _____ No _____ Proof of residency (Drivers License) _____

If student is transferring, give prior schools name and address _____

Has this student received special education services, if so describe and include dates _____

Does this student need special language considerations, if so describe _____
_____**FAMILY INFORMATION**

	FATHER	MOTHER	STEP PARENTS
NAME (first and last)			
LEVEL OF EDUCATION			
OCCUPATION			
HOME LANGUAGE			
MARITAL STATUS			
EMAIL ADDRESS			
WITH WHOM DOES CHILD LIVE?			

Legal Guardian (if different from parent) _____

List brothers and sisters of student enrolling:

Name	Gender	Date of Birth	Grade in School

MEDICAL AND EMERGENCY INFORMATION

Please list any chronic health problems, illnesses, accidents, operations, allergies, hospitalization or physical limitations (list causes and dates)

Is your child taking any medications? Yes _____ No _____

If yes, please request the "Administration of Medication in School" form. (This requires a physician's signature).

Name of Medication(s):

Dosage:

Time to be given:

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Where parents can be reached if not at home (work, pager, cell phone, etc.)

FATHER _____
Company Name City (Work) Phone Number (Cell) Phone Number Pager Number

MOTHER _____
Company Name City (Work) Phone Number (Cell) Phone Number Pager Number

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

NAME _____ Home Phone: _____
Cell Phone: _____

NAME _____ Home Phone: _____
Cell Phone: _____

In case of accident or serious injury or illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements deemed necessary.

PHYSICIANS NAME _____ Office Number: _____

HOSPITAL OF CHOICE: _____

Parent Signature: _____

Relationship to child (if not parent): _____