

TRANSFER INFORMATION

Last School Attended: _____ City & State _____

Was student attending this school on an inter-district transfer? Yes No Date of withdrawal: _____ Reason for withdrawal: _____

District of Residence (for Inter-district transfer students coming **INTO** Cottonwood Union School District: _____

Has the student ever gone by a different name? Yes No If yes, please give full name used: _____

Has the student been expelled/or in the process of being expelled from any school? Yes No Name of School _____

Has the student ever been to the SARB Board? Yes No If yes, reason for SARB & when _____

Is the student now enrolled/or has the student previously been enrolled in **special education** classes? Yes No Date of last IEP _____

If yes, please check the program RSP SDC Does the student have an active 504 Plan? Yes No

Is the student now enrolled, or has the student ever been enrolled in an English Language Development program (ELD) Yes No

Has the student been an English learner less than 12 months? Yes No Has the student ever received Title 1 Services? Yes No

MEDIA PERMISSION

I grant permission for identified school-related photographs or video of my child to be included in publicity information such as news releases, videos, newsletters, reports and district web site postings. Yes No

OTHER CHILDREN IN THE FAMILY

First and Last Name	Gender	Date of Birth	Lives @ Home	School Attending/Grade (if graduated, N/A)
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

OTHER PARENT OR LEGAL GUARDIAN INFORMATION not previously listed, if applicable.

Check *one* None Father Step-Father Mother Step-Mother Guardian Other _____

Name _____ Home Phone _____

First Last

Home Address _____

Street Address City State Zip

Work Phone _____ Cell Phone _____ Pager _____

Email Address _____ Extra Mailings? Grades Only?

If Foster or Group Home, name of organization: _____

Phone Number: _____ Name of Case Worker: _____

Is there a custody court order regarding this student? Yes No If **Yes**, please provide a copy of the court order to the school.

Check *one* None Father Step-Father Mother Step-Mother Guardian Other _____

Name _____ Home Phone _____

First Last

Home Address _____

Street Address City State Zip

Work Phone _____ Cell Phone _____ Pager _____

Email Address _____ Extra Mailings? Grades Only?

If Foster or Group Home, name of organization: _____

Phone Number: _____ Name of Case Worker: _____

Is there a custody court order regarding this student? Yes No If **Yes**, please provide a copy of the court order to the school.

EMERGENCY CONTACTS

List two *local* contacts to who the student may be released in the case of illness or other emergency if unable to notify parent.

Name _____	Name _____
Home Phone _____	Home Phone _____
Address _____	Address _____
Work Phone _____	Work Phone _____
Cell Phone _____	Cell Phone _____
Relationship _____	Relationship _____

ADDITIONAL CONTACTS

Additional contacts who the student may be released to.

Name _____	Name _____
Home Phone _____	Home Phone _____
Address _____	Address _____
Work Phone _____	Work Phone _____
Cell Phone _____	Cell Phone _____
Relationship _____	Relationship _____

In the event of a disaster, if parents or emergency contacts are not available, my son/daughter may be released to an adult familiar to him/her. Yes No

HEALTH INVENTORY

Student's Physician _____

Doctor's Name	Street Address	City	Phone Number
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Student's Dentist _____

Dentist's Name	Street Address	City	Phone Number
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Hospital Preference _____

Do you have Health Insurance? Yes No If yes, Name of Insurance Co. _____ Policy # _____

Do you have a religious or other objection to your child receiving emergency medical care? Yes No If yes, please explain: _____

Current Medication(s) Yes No

State law requires written doctor and parent permission for taking any medication at school. Please obtain a form from the school office.

If yes, Name of Medication(s)	Dosage	Time Taken	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there a special health problem or physical disability that should be brought to the attention of the school nurse or teacher? Yes No

If yes, please explain: _____

According to appropriate grade level schedules, all children will receive vision, hearing and dental screening. You have the right to refuse these services for your child. Unless you notify the office in writing, your child will be screened at no expense to you. My 7th grade daughter / 8th grade son may participate in the free scoliosis screening: Yes No

Health Problems Check all that apply:

- | | | | |
|-------------------------------------------------------|---------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------|
| Diagnosed ADD or ADHD..... <input type="checkbox"/> | Epilepsy..... <input type="checkbox"/> | Wears Glasses..... <input type="checkbox"/> | For close work <input type="checkbox"/> |
| Asthma..... <input type="checkbox"/> | Eye Injury..... <input type="checkbox"/> | For distance only <input type="checkbox"/> | At all times <input type="checkbox"/> |
| Bladder Problems..... <input type="checkbox"/> | Hypoglycemia..... <input type="checkbox"/> | Known Hearing Loss <input type="checkbox"/> | Right <input type="checkbox"/> Left <input type="checkbox"/> |
| Bleeding Disorder..... <input type="checkbox"/> | Frequent Nosebleeds..... <input type="checkbox"/> | Known Vision Loss... <input type="checkbox"/> | Right <input type="checkbox"/> Left <input type="checkbox"/> |
| Color Vision Deficiency..... <input type="checkbox"/> | Scoliosis..... <input type="checkbox"/> | Wears Hearing Aide.. <input type="checkbox"/> | Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> |
| Diabetes..... <input type="checkbox"/> | Seizure Disorder..... <input type="checkbox"/> | | |
| Eczema/Skin Trouble..... <input type="checkbox"/> | Wears Contact Lens..... <input type="checkbox"/> | | |

- | | | |
|----------------------------------------------------------|----------|-------|
| History of Ear Problem..... <input type="checkbox"/> | Describe | _____ |
| Heart Problem..... <input type="checkbox"/> | Describe | _____ |
| Head Injury..... <input type="checkbox"/> | Describe | _____ |
| History of Fracture..... <input type="checkbox"/> | Describe | _____ |
| History of Hospitalization..... <input type="checkbox"/> | Describe | _____ |
| History of Surgery..... <input type="checkbox"/> | Describe | _____ |
| Physical Limitations..... <input type="checkbox"/> | Describe | _____ |
| Other or further details of above | | _____ |

Allergies Check all that apply:

- | | | |
|---------------------------------|------------------------------------|-----------------------------------------------------|
| None <input type="checkbox"/> | Animals <input type="checkbox"/> | List specific item(s) student is allergic to: _____ |
| Food <input type="checkbox"/> | Insects <input type="checkbox"/> | Describe allergic reaction or treatment: _____ |
| Drugs <input type="checkbox"/> | Bee Sting <input type="checkbox"/> | _____ |
| Plants <input type="checkbox"/> | Other <input type="checkbox"/> | _____ |

Permission for Medical Records

I/We GIVE consent to the Cottonwood Union School District to receive from or send to the doctors listed above any information concerning the health and safety of my child. (Doctors or dentists may also require parent permission to release information.) Yes No

EMERGENCY MEDICAL AUTHORIZATION

I understand that the Cottonwood School District does not provide medical or accident insurance for students in school related injuries. Parents may purchase medical insurance. Information about this option is available from the Health Clerk.

Optional Emergency Treatment Authorization: We hereby authorize the staff of my child's School District to secure emergency medical help for our child at our expense when necessary in accordance with information on this form.

To Physician or Emergency Personnel: I give permission for emergency treatment if I am not available.

On _____ at _____, California.

Date

City

Parent/Guardian Signature(s) _____

I/We have reviewed this Registration Form and to the best of my/our knowledge the information contained herein is true and complete.

The undersigned declare under penalty of perjury that they are the parents or legal guardians of the above named student and grant the above authorizations.

PRIMARY PARENT OR GUARDIAN (from page one)

PRIMARY PARENT OR GUARDIAN (from page one)

Please print full name

Please print full name

Signature

Signature

Phone _____
Best number between 7:00am and 5:00 pm Monday-Friday

Phone _____
Best number between 7:00am and 5:00 pm Monday-Friday