

Registering For:
 School: _____
 Grade: _____

Bradley County Schools

Registration Form

When a call is made about your child, what number should we call?

1. _____
 2. _____

Student Name (as it appears on the Birth Certificate): _____ Preferred Name: _____

Last: _____ First: _____ Middle: _____

Gender/Sex: _____ Date of Birth: _____ Student's Social Security Number _____

Country of Birth: _____ State of Birth: _____ County of Birth: _____ City of Birth: _____

ETHNICITY (Circle one): Hispanic or Non-Hispanic

RACE (Circle ALL that apply): Asian American Indian/Alaskan Native Black/African American Pacific Islander / Native Hawaiian White

Student's Address: _____
 Number Street Name City State Zip

Home Phone Number: _____ List other Children in Family: _____

Special Services he/she receives: Resource ____ Title I Reading ____ Title 1 Math ____ Speech ____ Does he/she have an IEP? ____ or 504 plan? ____

****** EMERGENCY CONTACT (Other than Parent)** Phone: _____
 Name: _____ Relationship: _____
CHECK OUT INFORMATION: _____ may check out my child.

CUSTODY: BOTH PARENTS MOTHER FATHER STATE CUSTODY OTHER-LEGAL GUARDIAN

Are there Legal/Custody issues we should be aware of? Yes ___ No ___ What? _____

FATHER'S NAME: _____ **MOTHER'S NAME:** _____ **MAIDEN:** _____

Address: _____ Address: _____

Home #: _____ Cell #: _____ Home #: _____ Cell #: _____

Work #: _____ Email: _____ Work #: _____ Email: _____

Employed By: _____ Employed By: _____

CUSTODY OTHER - LEGAL GUARDIAN'S NAME: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____ Email: _____

Employed By: _____ **RELATIONSHIP TO STUDENT:** _____

Last School your child attended: _____ Address: _____

Last School Phone: _____ Last School Fax: _____ City: _____ State: _____ Zip: _____

For children entering Kindergarten or First Grade (Circle if attended) Pre-school Day Care Kindergarten

There MUST be a complete medical examination for every student entering school. The required TN Child Health Record must be on the Certificate of Immunization developed and authorized by the TN Department of Health. The immunization and physical exam will be recorded on the Certificate and placed in the student's school record. Children entering Kindergarten must be five years of age on or before August 15 (MUST have proof of birth). Children entering First Grade must have attended a State Approved Kindergarten.

Do you plan to enter another school next year? Yes ___ No ___ Where? _____

Parent or Legal Guardian's Signature: _____ Date: _____

Please complete both sides

FOR OFFICE USE ONLY: PRIORITY _____ BUS _____ TEACHER ASSIGNED _____ FIRST DAY OF SCHOOL _____

STUDENT MEDICAL INFORMATION – My student has the following health conditions that may require special care during school hours:

(check ONLY those that apply)

MY CHILD HAS NO SPECIAL HEALTH NEEDS

___ Asthma Triggers: _____
Treatment: ___ at home with medication
___ an inhaler will be needed and provided for use during school

___ Diabetes Treated with: ___ diet ___ insulin injections or pump

___ Food Allergy to: _____ Describe Reaction: _____
Current Required Treatment: _____

___ Other Severe Allergy to: _____ Describe Reaction: _____
Current Required Treatment: _____

___ Vision Impairment ___ glasses ___ contacts

___ Hearing Impairment ___ left ___ right

___ Physical Impairment Describe: _____

___ Seizure Disorder Type: _____
Treatment: ___ medicated at home
___ emergency medication is ordered and will be provided for use at school
Medication _____

___ ADD / ADHA ___ medicated at home
___ will require medication during school hours (as prescribed by MD)

OTHER MEDICAL ISSUES NOT LISTED ABOVE: _____

Parent or Guardian - Please initial each line to indicate you have read and understand the information below:

- ___ The information provided above is true and accurate to the best of my knowledge.
- ___ I acknowledge that students cannot transport medication of any kinds. The parent must bring medication into school and sign appropriate paperwork.
- ___ It is my responsibility to notify the school if my child's medical condition changes and/or they have developed any medical needs that may require attention during school hours.
- ___ The school may use over-the-counter first aid products such as Neosporin, Benadryl spray/cream, wound cleanser, etc (Topical First Aide) as needed for my student as they have no known sensitivity to these items. **This does not include medication taken by mouth.** ___ yes ___ no

HOME LANGUAGE SURVEY – In an effort to comply with Title VI of the Civil Rights Acts, we have been asked to survey parents to see if we are meeting the needs of students who may speak English as their second language.

1. What is the first language that your child learned to speak? _____
2. What language does your child speak most often outside of school? _____
3. What language do people usually speak in your child's home? _____

STUDENT RESIDENCY INFORMATION – As part of the NO CHILD LEFT BEHIND requirements, each school registrant should complete the following information.

WHERE DOES THE STUDENT STAY AT NIGHT? ___in his/her home owned/rented by parent ___in a shelter ___with a relative or friend (family does not have a residence) ___in a motel/hotel ___in housing that is inadequate (i.e. no electricity, running water, etc.) ___unsheltered (cars, parks, campgrounds, temporary trailer, abandoned building) ___other (explain): _____

Parent or Legal Guardian's Signature: _____ Date: _____