



STUDENT REGISTRATION FORM



A. Registration Details

School		School Year	20 __ / __	Date of Registration	MM / DD / YYYY
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B. Student Details

Last Name		First Name		Middle Name	
Gender	M / F	Date of birth	MM / DD / YYYY	City/Town of Birth	
Home address			Mailing address (if different)		
Address		Apt.		Address	
Town		Town		Zip code	
Zip code		Zip code		Home Phone	(_ _ _) _ _ _ - _ _ _ _
Home Phone	(_ _ _) _ _ _ - _ _ _ _	Student's Cell Phone (if applicable)	(_ _ _) _ _ _ - _ _ _ _	Student's email address	
Student's email address		Grade		School(s) previously attended	
Please check boxes that apply to the student, as appropriate:		<input type="checkbox"/> IEP	<input type="checkbox"/> 504	<input type="checkbox"/> Homeless	<input type="checkbox"/> Emancipation (over 16 only)

C. Demographics and Language Please answer all the questions in the section below

1.	Is the student Hispanic or Latino? (I.e. of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Please indicate the student's race by choosing one or more boxes.	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American
		<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
3.	Is the student an immigrant? (see note to right)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	To meet the federal definition of an immigrant student, a student must: 1. not have been in born in any state AND 2. not have completed three academic years of school in any state.		
	If student is an immigrant please provide the originating country.		
4.	Please provide the student's native language.		

D. Legal/Custody Issues

Is there a restraining order in effect regarding the student?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In relation to restraining orders or any other legal or custody issues provide details below or contact the school directly. Where relevant please also provide copies of current legal documents.		

E. Other School Age Children in Household Please provide details below

First Name	Last Name	DOB	School
		MM / DD / YYYY	
		MM / DD / YYYY	
		MM / DD / YYYY	

Official Use Only	LASID:					SASID:						LOCKER:	
	HOMEROOM:					STUDENT COUNSELOR:						HOUSE:	

F. Legal Parents/Guardians Please provide details of the student's Parents/Guardians. The contact information below will be used for all official correspondence and will be the first contacts in the case of emergency.

FIRST PARENT / GUARDIAN				SECOND PARENT / GUARDIAN				
First Name								
Last Name								
Relation to Student								
Home Address	Address		Apt.		Address		Apt.	
	Town		Zip code		Town		Zip code	
Mailing Address (if different)	Address			Address				
	Town		Zip code		Town		Zip code	
Home Phone	(_ _ _) _ _ _ - _ _ _ _			(_ _ _) _ _ _ - _ _ _ _				
Work Phone	(_ _ _) _ _ _ - _ _ _ _	Ext.	_ _ _	(_ _ _) _ _ _ - _ _ _ _	Ext.	_ _ _		
Cell Phone	(_ _ _) _ _ _ - _ _ _ _			(_ _ _) _ _ _ - _ _ _ _				
Email Address								
Place of employment								
Please indicate which apply	<input type="checkbox"/> Lives with student	<input type="checkbox"/> Can receive mailing	<input type="checkbox"/> Can collect student from school	<input type="checkbox"/> Lives with student	<input type="checkbox"/> Can receive mailing	<input type="checkbox"/> Can collect student from school		

G. Emergency contacts In the event of an emergency, **if the parents/Guardians cannot be reached**, the designated Emergency Contacts below will be contacted in the order listed (please provide at least one contact below).

	First Name	Last Name	Phone	Relation to student	Can pickup?
1			Home (_ _ _) _ _ _ - _ _ _ _		<input type="checkbox"/>
			Cell (_ _ _) _ _ _ - _ _ _ _		
2			Home (_ _ _) _ _ _ - _ _ _ _		<input type="checkbox"/>
			Cell (_ _ _) _ _ _ - _ _ _ _		
3			Home (_ _ _) _ _ _ - _ _ _ _		<input type="checkbox"/>
			Cell (_ _ _) _ _ _ - _ _ _ _		

H. Transport Please indicate which method of transport the student will use to travel to and from school (elementary and intermediate schools only)

To school:	<input type="checkbox"/> Bus	<input type="checkbox"/> Walk	<input type="checkbox"/> Drop off	<input type="checkbox"/> Other. Please provide details:	
From School:	<input type="checkbox"/> Bus	<input type="checkbox"/> Walk	<input type="checkbox"/> Pick up	<input type="checkbox"/> Other. Please provide details:	
If student is to be dropped off / picked up by someone other than guardians / contacts already named above, please provide details.					
First Name		Last Name		Phone	(_ _ _) _ _ _ - _ _ _ _

I. Confirmation

Parent/Guardian Signature _____	Date _____
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Medical Information for the School Nurse

Student's Name _____

Health insurance company _____					
(If no health insurance contact the school nurse for assistance)					
Physician Name			Dentist Name		
Physician's Phone			Dentist's Phone		
Date of last physical			Date of last dental exam		
Date of last eye exam		Current height		Current weight	
Please provide details and reasons of any medication the student takes regularly.					
Please check all conditions that apply to the student.					
<input type="checkbox"/> Asthma / Respiratory Problems		<input type="checkbox"/> Migraine Headaches		<input type="checkbox"/> Concussions/neck injury	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Cardiac Conditions/ Hypertension		<input type="checkbox"/> ADHD/ADD	
<input type="checkbox"/> Neurological		<input type="checkbox"/> Congenital Conditions		<input type="checkbox"/> Carries an EpiPen due to a current anaphylaxis episode.	
<input type="checkbox"/> Gastrointestinal Problems					
<input type="checkbox"/> Allergies (food, insects, medication, environment). Please provide details here, particularly any anaphylactic reactions and the date of the last anaphylactic reaction.					
<input type="checkbox"/> Other Medical Conditions (please specify).					
Hearing Problems		<input type="checkbox"/> Left Ear		<input type="checkbox"/> Right Ear	
		<input type="checkbox"/> Hearing Aids			
Vision Problems		<input type="checkbox"/> Wears Glasses		<input type="checkbox"/> Wears Contact Lenses	
Are there any Mental Health Concerns you wish to discuss with the school nurse			<input type="checkbox"/> Please provide details if you wish		
<input type="checkbox"/> Currently in counseling			Name of counselor: _____		
<input type="checkbox"/> Any major changes in family life in this past year? (if so please provide details in adjacent box)					
For students in grades 6-12 only: Please check the box to indicate your consent for over the counter medications including antacids, to be administered to your student, at the discretion of the school nurse. Up to ten doses of Acetaminophen may be administered to students in grades 6-12 only, and up to ten doses of Ibuprofen may be administered to students in grades 9-12 only.					<input type="checkbox"/>
In the event of illness or accident to a child or children of mine attending school, which in the judgment of the school nurse, principal, housemaster or administrator would seem to demand prompt medical treatment, the child/ children will be transported to the nearest hospital.					
SIGNATURE of Parent/Guardian _____ Date _____					

Massachusetts Immunization Requirements					
Kindergarten			7th Grade		
3 doses of Hep B	5 Doses of DTaP/DTP	2 doses of Varivax	3 doses of Hep B	1 booster dose of Tdap	2 doses of MMR
4 doses of Polio	2 doses of MMR	Lead Screening	4 doses of Polio	5 doses DTaP/DTP	2 doses of Varivax
Preschool Vision Screening					