Office Use Only
Student # _________ Family # ________
Homeroom ________ Grade __________
Enrollment Date ___________________
Birth & Immunization Records ________
Dental Records _____________________

SHERMAN CENTRAL SCHOOL

STUDENT REGISTRATION FORM

(Please complete all information)

Grade_Level_________

_________________________ _______ ___________________ ______________

STUDENT'S LEGAL LAST NAME Jr.,II,etc. FIRST NAME MIDDLE NAME GENDER: male___ female___

Birth Date________________ Birth City __________________ State_______ Country _________ STUDENT'S SS#________-_______-____________

Street/RD Address_______________________________________City___________________PO Box Address_________________________________

Home Telephone______________________Unlisted? Yes___ No___ [Message phone ___________________ Name ___________________________]

Name of last school attended:____ Date left_________________ Phone (_____)___________________

Address of last school: Street____ City_________________________ State__________ Zip________

Has student ever attended Sherman Central School before? Yes ____ No ____ If yes what year? _______________

Date of 1st Polio Shot________________________ **Student's Cell Phone #____**

Ethnic Origin
Am.Indian____ Asian_____ Afr-Am.____ Caucasian_____ Hispanic_____

Language spoken in home:
Eng.____ Spanish_____ Other______________

(Elementary Students Only) - NAME OF PRESCHOOL ATTENDED____

FAMILY INFORMATION

PRIMARY FAMILY

Guardian living with student (**If other than natural parent, PROOF OF GUARDIANSHIP must be provided)**

Relationship to child: ___natural parent ___ step ___ foster
___ other (list) _________________________

____________________ __________________ _________

Last Name *First Name* *MI*

Employer ____ Shift______ Work Phone (___) ___________________ Ext._______________

Cell Phone _____________________ Pager_______________________ E-Mail ____

SPOUSE / OTHER (living with student)

Relationship to child: ___natural parent ___ step ___ foster
___ other (list) _________________________

____________________ __________________ _________

Last Name *First Name* *MI*

Employer ____ Shift______ Work Phone (___) ___________________ Ext._____________

Cell Phone _____________________ Pager_______________________ E-Mail ____

Maiden Name of child's natural mother ____

SECONDARY FAMILY **- COMPLETE ONLY IF PARENTS ARE DIVORCED / SEPARATED AND THERE IS JOINT CUSTODY**

Relationship to child: ___natural parent ___ step ___ foster
___ other (list) _________________________

____________________ __________________ _________

Last Name *First Name* *MI*

Address____ Home Phone ______________________________

Employer ____ Shift______ Work Phone (___) ___________________ Ext.______________

Cell Phone _____________________ Pager_______________________ E-Mail ____

SPOUSE / OTHER

Relationship to child: ___natural parent ___ step ___ foster
___ other (list) ______________________________

____________________ __________________ _________

Last Name *First Name* *MI*

Employer ____ Shift______ Work Phone (___) ___________________ Ext._____________

Cell Phone _____________________ Pager_______________________ E-Mail ____

PLEASE COMPLETE SIDE 2

EMERGENCY INFORMATION - The following person(s) are to be contacted in this order if parent cannot be reached:

Name	Relationship	Home Phone	Cell/Work #	Address
1st				
2nd				
3rd				

Besides parents and the persons listed above, my child MAY BE PICKED UP AT SCHOOL BY:

Name	Relationship	Home Phone	Cell/Work #	Address

SIBLINGS: List all other children living in your household for census purposes.

Last Name	First Name	Birthdate	Gender M / F	School Attending

STUDENT SHOULD **NOT** *BE RELEASED TO:*

(NOTE: IF THIS PERSON IS THE BIOLOGICAL PARENT, THE SCHOOL MUST HAVE LEGAL DOCUMENTATION ON FILE IN ORDER TO DENY THE BIOLOGICAL PARENT ACCESS)

NAME____

RELATIONSHIP TO CHILD____________________________

What type of **MEDICAL COVERAGE** does the student have?

___ Blue Cross/Shield ___ Univera ___Independent Health
___ Community Blue ___ Fidelis __Child Health + ___ Family Health +
___ Medicaid ___ No Health Insurance ___Unknown

Does the student have a regular doctor or clinic?

____NO ____YES – Health Care Provider ______________________

DID YOUR CHILD RECEIVE ANY OF THE FOLLOWING SERVICES AT THE FORMER SCHOOL?

____Speech ____Writing ____Remedial Math ____Remedial Reading ____Occupational Therapy ____Resource Room/Inclusion (I.E.P.)

____Gifted/Talented ____Special Ed. (I.E.P.) ____Counseling ____Physical Therapy ____Free Lunch ____Reduced Lunch

____ Medication / Treatment at school (please indicate in the section below)

ARE THERE OTHER INSTRUCTIONS OR RESTRICTIONS THE SCHOOL SHOULD KNOW ABOUT? (I.E. allergies, chronic medical conditions, medications / treatment, behavioral issues, etc.)

IN THE EVENT OF AN EMERGENCY EVACUATION OF THE SCHOOL, MY CHILD IS TO PROCEED AS FOLLOWS:

	Walk or Bus (Bus #?)	Name	Relationship to Child	Contact Number(s)	Address
1st Choice					
2nd Choice					

PARENT/GUARDIAN SIGNATURE____ DATE________________________

If any of the information you have provided changes during the school year, please be sure to notify the school office immediately.