

**COTTONWOOD UNION SCHOOL DISTRICT
2023/2024 SCHOOL YEAR
REGISTRATION FORM**

North Cottonwood

West Cottonwood

Student's Legal Name: _____				Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> N		
<small>(from Birth Certificate)</small>		Last	First	Middle		
Grade: _____	Birthday: ____/____/____					
Residence Address: _____						
		Street	City	Zip	County	
Mailing Address if different: _____						
			Street or P.O. Box	City	Zip	
Home Phone Number: _____				Unlisted? Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Student Email: _____						

PARENT/GUARDIAN INFORMATION Who does the student live with? _____

Please enter one parent per side

Relation to Student: _____

Name: _____

First Last

Home Address _____ **City** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Employer _____ **Employer Phone** _____

Email Address _____

Military? Yes / No

Parent Education Level (for state testing purposes)

No Diploma High School Graduate

Some College/AA College Graduate

Graduate School/PhD Decline to state/unknown

Relation to Student: _____

Name: _____

First Last

Home Address _____ **City** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Employer _____ **Employer Phone** _____

Email Address _____

Military? Yes / No

Parent Education Level (for state testing purposes)

No Diploma High School Graduate

Some College/AA College Graduate

Graduate School/PhD Decline to state/unknown

Residence – Where is your child/family currently living?

This information is federally mandated by No Child Left Behind – Please check appropriate box(es)

- | | |
|---|--|
| <input type="checkbox"/> In a single family permanent resident – house, apartment, condominium, mobile home (20) | <input type="checkbox"/> In or awaiting foster care placement (21) |
| <input type="checkbox"/> With more than one family in a house or apartment (11) | <input type="checkbox"/> In a motel (09) |
| <input type="checkbox"/> With friends or other family members – other than parents, grandparents, or legal caregiver (11) | <input type="checkbox"/> In a group home (14) |
| <input type="checkbox"/> In a shelter or transitional housing program (10) | <input type="checkbox"/> In a car or campsite (12) |

Student's Ethnicity Is this student Hispanic or Latino? Yes No The previous question was about ethnicity, not race. **No matter what you just selected, please continue to answer the following** by making one or more selections to indicate what you consider the student's **race** to be. Write the number(s) on the line(s). _____

- 100-American Indian/Alaskan Native
- 201-Chinese
- 202-Japanese
- 203-Korean
- 204-Vietnamese
- 205-Asian Indian
- 206-Loatian
- 207-Cambodian
- 299-Other Asian
- 301-Hawaiian
- 302-Guamanian
- 303-Samoan
- 304-Tahitian
- 399-Other Pacific Islander
- 400-Filipino
- 600-Black or African American
- 700-White

Home Language Survey

1. Which language did your student learn when he or she first began to talk?
2. What language does your student most frequently use at home?
3. What language do you use most frequently to speak to your student?
4. Name the language most often spoken by the adults at home:

FOR SCHOOL USE ONLY		<input type="checkbox"/> EO	<input type="checkbox"/> I-FEP	<input type="checkbox"/> EL	<input type="checkbox"/> RFEP	Redes Date if RFEP _____
Grade Level _____	District of Residence _____	Interdistrict on file _____				
Date Enrolled _____	IS _____	CUM Rcv'd _____	School ID # _____	Group # _____		
CSIS # _____	HmRm _____	Bus # _____	Scheduled _____			

TRANSFER INFORMATION

Last School Attended: _____ City & State _____

Was the 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 website postings. Yes No

OTHER CHILDREN IN THE FAMILY

First and Last Name	Gender	Date of Birth	Lives at 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 whom the student may be released in the case of illness or other emergency if unable to notify parents.

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

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

ADDITIONAL CONTACTS

Additional contacts who the student may be released to.

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

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

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

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.

Name of Medication	Dosage	Time Taken	Purpose

Are any of these medications to be administered at school? Yes No If yes, you MUST have a Doctor complete a Medication Authorization Form.

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.

No, I do not want my child participating in these screenings

Health Problems Check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Diagnosed ADD or ADHD | <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Known Hearing Loss |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Right |
| <input type="checkbox"/> Carries Inhaler | <input type="checkbox"/> Frequent Nose Bleeds | <input type="checkbox"/> Left |
| <input type="checkbox"/> Inhaler in Nurses Office | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Known Vision Loss |
| <input type="checkbox"/> No inhaler needed | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Right |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Wears Contact Lens | <input type="checkbox"/> Left |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Wears Glasses | <input type="checkbox"/> Wears Hearing Aids |
| <input type="checkbox"/> Color Vision Deficiency | <input type="checkbox"/> For Distance Only | <input type="checkbox"/> Right |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> For Close Up Only | <input type="checkbox"/> Left |
| <input type="checkbox"/> Eczema/Skin Trouble | <input type="checkbox"/> At All Times | |
| <input type="checkbox"/> Epilepsy | | |
| <input type="checkbox"/> History of Ear Problem | Describe _____ | |
| <input type="checkbox"/> Heart Problem | Describe _____ | |
| <input type="checkbox"/> Head Injury | Describe _____ | |
| <input type="checkbox"/> History of Fracture | Describe _____ | |
| <input type="checkbox"/> History of Hospitalization | Describe _____ | |
| <input type="checkbox"/> History of Surgery | Describe _____ | |
| <input type="checkbox"/> Physical Limitations | Describe _____ | |

Other or further details of above:

Allergies Check all that apply:

- | | | |
|---------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Animals | <input type="checkbox"/> Insects |
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Bee Sting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Plants | <input type="checkbox"/> Food | |

List specific item(s) student is allergic to: _____

Describe allergic reaction or treatment: _____

Allergy treatment needed at school? Yes No If yes, describe:

Permission for Medical Records

I give consent and authorize Cottonwood Union School District to receive from or send to the doctors listed above, in this form, any medical, medication, vision, mental health, audiological and/or educational information concerning the health and safety of my child. (Doctors or dentists may also require parent permission to release information.) This shall become effective immediately and remain effective until the end of the school year. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

Date

Printed Name of Parent/Guardian

Signature of Parent/Guardian

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