Kindergarten Registration

*****Student must turn 5 by August 1, 2020**

1. Complete the Student Information Form, and Health History Form.
2. Take a picture of your child's Birth Certificate, and Shot Record and email it to rhkindergartenregistration@rockhill.org.

*****If your child attended RH Preschool last year we do not need a copy of Birth Certificate or shot record unless they have recently gotten new shots.**

STUDENT INFORMATION SHEET

(PLEASE PRINT AND ANSWER ALL INFORMATION)

LAST NAME:_____

NAME SUFFIX (e.g. Jr., I, II, III)_____

FIRST NAME_____

MIDDLE NAME_____

ADDRESS_____

CITY:_____

STATE:_____ZIP CODE_____

TELEPHONE (AREA CODE + NUMBER)_____

PARENT / GUARDIAN NAME:_____

RELATION TO STUDENT_____

MOTHER'S MAIDEN NAME_____

STUDENT'S SEX (MALE OR FEMALE)_____

ETHNIC CODE: (CIRCLE ONE) CAUCASIAN, AFRICAN AMERICAN, HISPANIC, ASIAN, AMERICAN INDIAN

NATIVE LANGUAGE_____

BIRTHDATE_____, _____, _____

MONTH DAY YEAR

BIRTHPLACE OF STUDENT_____, _____

CITY STATE

STUDENT SOCIAL SECURITY NUMBER_____-_____-_____

DO YOU LIVE IN THE ROCK HILL DISTRICT_____

IF NO, WHICH DISTRICT_____

ARE YOU THE LEGAL GUARDIAN OF THE STUDENT_____

DOES YOUR CHILD HAVE AN IEP? _____

DOES YOUR CHILD HAVE A 504? _____

Rock Hill Local School District

Health History

Student's Name	Sex	Date of Birth

Student Health Conditions:

[ ] Allergies
[ ] Asthma
[ ] ADD / ADHD
[ ] Autism
[ ] Behavior concerns
[ ] Birth/Congenital malformations
[ ] Bone/Muscle/Joint problems
[ ] Blood problems
[ ] Bowel/ Bladder problems
[ ] Cancer
[ ] Cystic fibrosis
[ ] Diabetes
[ ] Depression
[ ] Ear problem/hearing difficulty
[ ] Emotional concerns
[ ] Headaches
[ ] Heart problems
[ ] Hemophilia
[ ] Juvenile arthritis
[ ] Lead poisoning
[ ] Migraines
[ ] Neuromuscular disorder
[ ] NO medical conditions
[ ] Seizure disorder
[ ] Sickle cell anemia
[ ] Skin conditions
[ ] Speech problems
[ ] Traumatic brain injury
[ ] Vision problems (glasses/contacts)
[ ] other _____
[ ] other _____
[ ] other _____
[ ] other _____

Please explain any conditions above or any reasons for hospitalizations:

_____

_____

Please indicate any allergies your child may have:

Allergy type	Reaction	School restrictions or recommended actions
Bee/Insect	_____	_____
Food	_____	_____
Medication	_____	_____
Other	_____	_____

Please list any prescription and over the counter medication that your child takes on a regular basis:

Medication/Dose	Time	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?
Yes / No
If YES, please explain:_____

_____

_____

Does the student require any special procedures and/or treatments for their health condition(s)?
Yes / No
If YES, please explain: _____

_____

_____

Please indicate any other information about your child's health or development that you think would be helpful for the school to know: _____

_____

_____

_____ _____ _____

Form completed by | Relationship to student | Date