South Webster Jr./Sr. High School

Student Registration Form

Please PRINT Clearly

Today's Date _____

STUDENT

Legal Name: _____

First Middle Last Name to be Called

Address: _____

House # Street and PO Box # *City* *State* *Zip*

Home Phone: Is student Open Enrolled? OE form complete (**current** year)?

Grade Entering: Age: ☐ Male ☐ Female

SS# Mother's Maiden Name:

Date of Birth: Place of Birth:

City *State* *County*

Is the student Hispanic or Latino? ☐ Yes ☐ No

What is the student's race? <u>You must choose at least one.</u>

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Other Pacific Islander

Last School Attended: That School District:

Was student in special classes? (LD, CD, Speech, AG, Other):

If entering from out of State, what school in Ohio did student last attend?

Names and ages of student's siblings:

PARENT/GUARDIAN

	Father	Mother	Step-Father	Step-Mother	Guardian
Name					
Address					
Home Phone					
Cell Phone					
Employer					
Work Phone					
E-Mail					

Student lives with: ☐ Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Guardian ☐ Other_____

Who has custody? **Have you provided us with custody papers?**

South Webster Jr./Sr. High School

Emergency Medical Authorization Form

Please PRINT Clearly

Student _____

Address _____

_____

Grade (circle): 7 8 9 10 11 12

	Name	Mother	Father	Other
	Address			
	Home Phone			
	Work Phone			
	Cell Phone			

MEDICAL

Allergies _____

Date of last Tetanus shot _____

State physical restrictions (heart condition, diabetes, asthma) _____

Medications currently taking _____

AUTHORIZATION

Consent for Medical Treatment:

In the event reasonable attempt to contact me have been unsuccessful, I hereby give consent for the following medical care providers and local hospital to be called. I further consent to (1) the administration of any treatment deemed necessary, or, in the event the preferred practitioner is not available, by another licensed physician/dentist, and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

	Physician / Specialist	Dentist	Local Hospital
Name			
Phone			

Signature of Parent/Guardian: _____ **Date:** _____

REFUSAL

Refusal to Consent for Medical Treatment:

In the event of illness or injury requiring emergency treatment, I wish the school officials to take the following actions: _____

_____.

Signature of Parent/Guardian: _____ **Date:** _____

CONTACTS

LIST ADDITIONAL CONTACTS IN CASE WE ARE UNABLE TO REACH YOU IN THE EVENT OF AN EMERGENCY.

NAME_____ **PHONE**_____ **RELATION**_____

NAME_____ **PHONE**_____ **RELATION**_____

I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN THE 2010-2011 FIELD TRIP PROGRAM.

(This form will be copied and brought to each field trip in which your child participates. The original will be kept in the office for school use.)

Signature of Parent/Guardian:_____ **Date:**_____