SHEPHERD ELEMENTARY SCHOOL ~ REGISTRATION FORM

CONFIDENTIAL INFORMATION: **GRADE: _____**

Ethnic Origin: Native American _____ Asian _____ Hispanic _____ Black _____ White _____
Native Hawaiian/Pacific Islander _____

Please check the following services your child is receiving:

Speech _____ Title/Invention _____ Counseling _____ Extended Studies _____ I.E.P. / Special Ed _____

STUDENT INFORMATION:

NAME: _____
(Legal Name on Birth Certificate) LAST FIRST MIDDLE

DATE OF BIRTH: _____-_____-_____ **BIRTHPLACE:** _____ **Gender:** Male ___ Female ___

SOCIAL SECURITY NUMBER: _____ **HOME PHONE NUMBER:** _____

PHYSICAL ADDRESS: _____

MAILING ADDRESS: _____
(Please write SAME if no change from Physical Address)

ZIP CODE: ***(Please select one)*** Shepherd, MT 59079 _____ Billings, MT_____ Zip_____ Other _____

FAMILY INFORMATION:

Father:

Name Home/Cell Number

Address *(If different from above)* Work Number

Email *(please give best email for sending information)*

Mother:

Name Home/Cell Number

Address *(If different from above)* Work Number

Email *(please give best email for sending information)*

Student Lives With: Mother ____ Father ____ Stepmother ____ Stepfather ____ Legal Guardian ____

Stepparent Name: _____

Legal Guardian *(If other than parent)*: _____

SCHOOLS ATTENDED THE LAST THREE YEARS

YEAR	SCHOOL	CITY	STATE

EMERGENCY CONTACT INFORMATION:

Please indicate a person(s) to contact in an emergency if a parent/guardian is not available:

Contact Name	Relationship to Student	Phone Number(s)
1.		
2.		
3.		

IMMUNIZATIONS:

Montana Law requires a record of adequate immunizations to be recorded at school or a special examination signed by physician or parent. The parent or guardian is responsible to provide the school with this information before admission into the school.

COPY OF CURRENT IMMUNIZATIONS: YES ____ NO ____

HEALTH HISTORY:

In the following list of diseases, please check those your child has had and give the year he/she had them, if known.

	Check	Year		Check	Year
Chickenpox			Asthma		
Measles (Hard)			Allergies or Hay Fever		
Rubella (3-day)			Eczema		
Scarlet Fever			Kidney Infection		
Whooping Cough			Rheumatic Fever		
Mumps			Epilepsy or Seizures		
Frequent Colds			Convulsions		
Ear Infections			Diabetes		
Sinusitis			Heart Disease		
Orthopedic Problems			Congenital Conditions		

What operations, serious accidents or serious illnesses has your child had?

_____

_____

Will your child be taking medication at school? YES ____ If so, please fill out the required form.
PLEASE GET THE FORM FROM THE OFFICE

Is your child on medication? YES ____ NO ____ If so, please list the name and the dosage below:

MEDICATION NAME	DOSAGE

**** HEARING TESTS ****

Pure tone hearing screening is mandated for grades K, 1 and 10. Students in all grades will be screened if they are **NEW** to the school, on the annual hearing recheck list, or referred by a school staff and/or by the parent-guardian.

Child's Doctor: _____

Child's Dentist: _____

Hospital Preference: St. Vincent _____ Billings Clinic _____

It is understood a conscientious effort will be made to locate the parent or guardian before any action will be taken, but if it is not possible to locate the parent/guardian, the expense will be accepted by me. If the above named emergency contacts are not available, I authorize care by a physician on call at the hospital.

*****Please note the hearing test information box just above*****

Parent: _____ Date: _____

Legal Guardian: _____ Date: _____

(You Must Provide a Copy of the Court Order)