Steubenville City Schools

Student Registration Form

Grades 1 - 4

For Office Use Only / Leave Blank

Student # _____

Student Name _____

School Year _____ ***Teacher***_____

Steubenville City Schools
Steubenville, Ohio 43952
School Registration Form

Student # (office only) Enrolling in Grade Date

Legal Name (Last) (First) (Middle) Nickname

Street Address (Street) (City) (State) (Zip Code)

Date of Birth Age Place of Birth

Gender ☐ Male ☐ Female Social Security Number

The United States Department of Education, under the No Child Left Behind Act, mandates that school districts collect and report the following racial and ethnic data. The purpose for collecting this information is to "ensure equal access" to education for all students.

Racial/Ethnic Code: (Required by the State of Ohio) Is Child Hispanic? ☐ Yes ☐ No If No Check all that apply

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White

Is this child a U.S. Citizen ☐ Yes ☐ No Language spoken in the home

With whom does this child reside? (Last) (First) (M.I.)

Does this person have legal custody? ☐ Yes ☐ No
If NO then who does have legal custody?

Legal Name (Last) (First) (M.I.)

Current Address (Street) (City) (State) (Zip Code)

Home Phone Cell Phone

RESIDENCY: Information concerning person(s) with whom the student is living.

☐ Father ☐ Stepfather ☐ Guardian ☐ Foster Father

Name Home Phone Cell Phone

Employer Business Phone

☐ Mother ☐ Stepmother ☐ Guardian ☐ Foster Mother

Name Home Phone Cell Phone

Employer Business Phone Maiden Name

Are you, as legal guardian, residing with a relative or friend in the Steubenville School District?
☐ Yes? ☐ No?
State law requires that the school receive a copy of a divorce or separation decree, if applicable
The court papers show that I have legal custody of the student ☐ Yes ☐ No

List Student's siblings and grade level

(Last, First Name) (Grade) (Last, First Name) (Grade)

(Last, First Name) (Grade) (Last, First Name) (Grade)

CHILD'S Name:

HEALTH HISTORY

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

If yes, explain briefly

How old was the mother when this child was born?

Was this infant born: full term ☐ early ☐ late ☐ What was this infant's birth weight?

Did the infant have any sickness or problems while in the nursery? ☐ Yes ☐ No

If yes, explain briefly

DEVELOPMENTAL HISTORY Please give the approximate age at which this child:

walked alone | was toilet trained | spoke in sentences | dressed self

How does this child's development compare to other children, such as his or her brothers/sisters/playmates?

☐ about the same ☐ slower ☐ faster

HEALTH CONDITIONS Please check any that this child has had:

_____Abnormal spinal curvature (scoliosis, etc.)
_____Allergies or hay fever
_____Anemia
_____Arthritis
_____Asthma or wheezing
_____Bed wetting at night
_____Behavior problem
_____Birth or congenital malformation
_____Cancer, Type
_____Chronic diarrhea or constipation
_____Concern about relationship with siblings or friends
_____Cystic Fibrosis
_____Diabetes
_____Eczema
_____Emotional problems
_____Eye problems, poor vision
_____Frequent headaches
_____Frequent skin infections
_____Frequent sore throat infections
_____Heart disease, type
_____ Hepatitis
_____ Kidney Disease, type
_____ Measles ('Old Fashioned' or 'Ten Day')
_____ Meningitis or encephalitis
_____ Multiple ear infections (3 or more)""
_____ Mumps
_____ Near-drowning or near-suffocation
_____ Nervous twitches to tics
_____ Poisoning
_____ Poor hearing
_____ Pregnancy
_____ Rheumatic fever
_____ Seizures or epilepsy
_____ Sickle cell disease
_____ Stool soiling
_____ Substance abuse
_____ Suicide attempt
_____ Toothaches or dental
_____ Urinary tract infection
_____ Wetting during day

ALLERGIES Please list and describe allergies or reactions to:

Medicines/drugs

Foods/plants/animals/other

Recommended treatment if allergy is serve

INJURIES AND ILLNESSES Please list any severe injuries or illnesses:

Injuries Illnesses	Age of Child	If Hospitalized (check)
		☐
		☐
		☐
		☐
		☐
		☐

Completed By: Relationship to Child:

EMERGENCY MEDICAL AUTHORIZATION

Purpose

To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

Student Name

Steubenville City Schools
School District

Address

School Attended

Telephone

PART I OR II MUST BE COMPLETED

PART I
TO GRANT CONSENT

In the event reasonable attempts to contact me at (phone no.) or (other parent or guardian), at (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. , preferred physician, or Dr. , preferred dentist. In the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to preferred hospital or any hospital reasonably accessible.

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This authorization does not cover major surgery unless the medial opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Date

Signature of Parent or Guardian

Address

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II
REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I which the school authorities to take the following action:

Date

Signature of Parent or Guardian

Address

STEUBENVILLE CITY SCHOOLS

Authorization to Disclose Immunization Information

Name of Child _____ Date of Birth _____

I. _____ as the parent or guardian of the above named child.

Herby authorize (Name of Provider(s)):

_____

to disclose the specific and individually identifiable immunization records of the above named child to (Name of School);

_____

for the specific purpose of presenting written evidence, satisfactory to the person in charge of admission, that the above named child has been immunized by a method of immunization approved by the department of health as required by section 3313.671 of the Ohio Revised Code.

This authorization will expire upon the presentation of written evidence sufficient to comply with section 3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken by the above named Provider(s) or School in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the Information unless otherwise provided for by state or federal law. Please note: medical records provided to schools that receive federal funding are protected by the Family Educational Rights and Privacy Act (FERPA).

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service Is requested by a non-treatment provider (e.g.. insurance company) for the sole purpose of creating health information (e.g ., physical exam), service may be denied if authorization is not given.

I also understand that my refusal to sign this authorization may prevent the school from verifying that the above named child has been immunized. I further understand that if the school cannot verify and I cannot provide satisfactory written evidence that above named child has been immunized, the child may be excluded from school pursuant to section 3313.671 of the Ohio Revised Code.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Relationship/Authority)*

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NOTE: *This Authorization* was *revoked* on: _____ _____

(Date) *(Signature of Staff)*