Steubenville City Schools

Student Registration Form

Kindergarten

For Office Use Only / Leave Blank

Student # _____

Student Name _____

School Year _____ ***Teacher*** _____

Steubenville City Schools

Steubenville, Ohio 43952

School Registration Form

Student # _____ Enrolling in Grade Kindergarten Date _____
(office only)

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

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:

SECTION 3313.712, OHIO REVISED CODE

(Pursuant to Am. H.B. 1175)

(A) Annually the board of education of each city, exempted village, local, and joint vocational school district shall, before the first day of October, have provided to the parent or legal guardian of every pupil enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division *(B)* of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into a public school in this state for the first time, provide the parent or legal guardian of such pupil, either as part of any registration form which is in use in the district, or as a separate form an identical copy of the form contained in division (B) of this section.

When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a city, exempted village, local, or joint vocational school district to which the pupil is transferred. Upon request of his parent Or guardian, authorities of the school in which the pupil is enrolled may permit such parent or guardian to make changes in a previously filed form, or to file a new form.

If a parent or guardian does not wish to give such written permission, he shall indicate in the proper place on the form the procedure he wishes school authorities to follow in the event of a medical emergency involving his child.

Even if a parent or guardian gives written consent for emergency medical treatment, when a pupil becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extra-curricular activity authorized by the appropriate school authorities, the authorities of the school in which the pupil is enrolled shall make reasonable attempts to contact the parent or guardian before the treatment is given. The school shall present the pupils emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section.

(B) The emergency medical authorization form provided for in division (A) of this section is as follows: *(See reverse side).*

Dear Parents,

We value your input and ideas. We would like you to take a few minutes to complete this questionnaire and return it to school with your child(ren).

Name: **Name of Child(ren)**

1) Would you be willing to participate in a district support group? ☐ Yes ☐ No

2) Would you be willing to attend workshops on various topics related to parenting and helping your child succeed in school? ☐ Yes ☐ No

3) Please check the workshop days and times you would prefer:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday

☐ Mornings ☐ Afternoon ☐ Evenings (6-8)

4) Please check your preference for location of workshops:

☐ Your Home School ☐ High School Conference Center ☐ Other

5) Please check workshop topics that you are interested in and most likely to attend:

☐ Parenting Class
☐ Discipline
☐ Self-Esteem
☐ Stress/Coping Skills
☐ Parents with Careers
☐ Single Parenting
☐ Homework Help
☐ Wellness Program
☐ Available Community Services
☐ Reading and Writing with your Child
☐ Step Families
☐ Creativity and Critical Thinking
☐ Make-It-Take-It
☐ Other:

6) Please list any other ideas that you may have to increase parental involvement.

Thank you for your time and ideas! Form used in Steubenville City Schools since 1990.

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)*

****

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

(Date) *(Signature of Staff)*

IMMUNIZATIONS REQUIRED FOR KINDERGARTEN ENROLLMENT

1. 5 DOSES OF DPT (Diphtheria, Pertussis, Tetanus) if the fourth does was given before the fourth birthday, if given after- only 4

2. 4 DOSES OF POLIO- on or after the fourth birthday

3. 2 DOSES OF MMR (Measles, Mumps and Rubella)

4. 3 or 4 HIB VACCINES

5. 3 DOSES OF HEP B (Hepatitis B) VACCINE

6. 2 DOSES OF VARICELLA VACCINE

Child Medical Statement

Childs' Name_____ Date of Birth_____

Height _____ Weight_____

Limitations or health condition (including allergies, medications, dietary restrictions)

Immunizations	**Please circle one**	
Complete for age	Yes	No
In Process	Yes	No

Exempt from Immunizations	**Please circle one**	
Religious conviction	Yes	No
Health concern	Yes	No
Other:		

This child has been examined and is in suitable condition to participate in group care

Signature of examining Physician/ Physicians Assistant or Advanced Practice Nurse (circle one) Address : Phone:	Date of exam

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program				Reason not completed (Check which applies)	
Assessments/Screenings	Completed **Please circle one**		Date Completed	Health professional decision	Examples: religious conviction, insurance coverage, other
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			