CCS_Form#15a_rev5

Grade: ____Homeroom:_____

Student Registration

PARENTS COMPLETE THIS FORM, SIGN, AND RETURN TO YOUR CHILD'S SCHOOL

STUDENT LEGAL NAME _____ **BIRTH DATE** _____ **RACE** _____**GENDER**_____

MAILING ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

PHYSICAL ADDRESS_____

BUS # IN A.M._____ **BUS # IN P.M.**_____ **STUDENT CELL** _____

IS THIS STUDENT IN FOSTER CARE? Please circle YES or NO **IS THIS STUDENT A SINGLE PARENT?** Please circle YES or NO

NAME(S) OF PERSON WHO HAS LEGAL CUSTODY OF THE STUDENT?_____

EMAIL_____ PHONE (H) _____ (C)_____ (W)_____

MOTHER'S NAME _____EMAIL _____

Does Child live with mother? Please circle YES or NO PHONE (H) _____ (C)_____ (W)_____

FATHER'S NAME _____ EMAIL _____

Does Child live with father? Please circle YES or NO PHONE (H) _____ (C)_____ (W)_____

1st EMERGENCY CONTACT PERSON _____ PHONE _____

Does Child live with this contact? Please circle YES or NO Relationship:_____

2nd EMERGENCY CONTACT PERSON_____PHONE _____

Does Child live with this contact? Please circle YES or NO Relationship:_____

LIST ANY MEDICAL PROBLEMS OR CONDITIONS THAT YOUR CHILD HAS THAT THE TEACHER/SCHOOL SHOULD BE AWARE OF:

_____

IF YOUR CHILD ROUTINELY TAKES ANY MEDICATIONS, PLEASE LIST HERE:

_____

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH FOOD, INSECT, OR MEDICATION ALLERGIES? _____ If yes, please list allergies here:_____

Is your child currently prescribed, by a physician/health care provider, an Epi-Pen or inhaler? _____If yes, you must provide the school with an asthma and or allergy action plan written and signed by the health care provider for the current school year.

DOES/DID YOUR CHILD HAVE AN IEP AT THIS OR ANOTHER SCHOOL? Please circle YES or NO . If yes, please sign here so we can request those records from the previous placement _____

Certain state mandated screenings are given each year to specified grades. If results are not within normal limits, you will be notified. To opt out of health screening you must notify the principal in writing.

In case of emergency, I (We) give our permission for school personnel to render first aid treatment and to send my child to a medical facility for treatment in the event I cannot be reached by phone. I will notify the school office of any changes in the information listed on this form.

Always give medications at home if at all possible. School personnel will assist with the self-administration of prescription/non-prescription medications in the unlikely event that it cannot be given at home by parent/guardian. This will be at the request of and as an accommodation to the parent/guardian. By signing this form, I understand that it is my responsibility to furnish medication in the original container with the student's name, doctor's name, name of medication, and directions on the container accompanied by a parent/guardian note.

Cocke County Schools

STUDENT PICK-UP LIST

Dear Parent/Guardian,
To help complete our information on your child's protection, please complete this form.

NAME OF CHILD _____ **SCHOOL**_____

Only the following people have permission to pick up my child from school.

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List anyone who is <u>NOT</u> to pick up your child:_____
_____
_____

If anyone comes to pick up your child whose name is not on this list, they must have a permission slip with your signature and phone number where you can be reached to verify the pickup. We can not release your child without verifying your permission.

If there are custody papers in effect concerning your child/grandchild, please be sure the school office has a copy of that record.

_____
Parent/Guardian signature Date
Phone to call for permission verification_____