

Garfield School District Pupil Registration

Pupil's Legal Name _____
Last First Middle Nickname

Address _____
Street Address City State Zip

Mailing Address (if different) _____ **email** _____
Street address City Zip

Female **Male** **Birthdate** _____ **Grade level** _____
Month / day / year

Birthplace _____ (Please provide copy of Birth Certificate)
City State Country

School last attended _____ **School address** _____
City State

Has attended preschool yes no **If yes, how long** _____ **Where** _____

Preschool: Name _____ **Address** _____

Parent/Guardian Information Student resides with (check one or complete "other" blank)
Both Parents Mother Father Step-Parent Legal Guardian(s) Other _____

Mother _____
Name Occupation Employer Phone email

Father _____
Name Occupation Employer Phone email

Step-Parent _____
Name Occupation Employer Phone email

Legal Guardian _____
Name Occupation Employer Phone email

Siblings (under 18 years of age):

Name _____ Birthdate _____ Gender Male Female
Name _____ Birthdate _____ Gender Male Female
Name _____ Birthdate _____ Gender Male Female
Name _____ Birthdate _____ Gender Male Female
Name _____ Birthdate _____ Gender Male Female

If student was not born in the United States, please provide the following information:

Entry date to USA _____ Country of Origin _____ Entry date 1st US school _____

Home Language Survey

Which language did the student learn when he/she first began to talk? _____
What language does the student use most at home? _____
What language do you use most frequently to speak to the student? _____
Name the language most often spoken by adults at the student's home _____

Special Education

Has your child ever received special instructions in the English language? Yes No
Does your child have an IEP If so, what institution holds these records _____

Ethnicity

Is this student Hispanic or Latino? Y N

Race

Regardless of what you selected for ethnicity, please mark one or more boxes to indicate what you consider your child's race to be:

- | | | |
|---|------------------------------------|---|
| American Indian or Alaska Native <input type="checkbox"/> | Guamanian <input type="checkbox"/> | Other Asian <input type="checkbox"/> |
| Asian Indian <input type="checkbox"/> | Hawaiian <input type="checkbox"/> | Other Pacific Islander <input type="checkbox"/> |
| Black or African American <input type="checkbox"/> | Hmong <input type="checkbox"/> | Samoan <input type="checkbox"/> |
| Cambodian <input type="checkbox"/> | Japanese <input type="checkbox"/> | Tahitian <input type="checkbox"/> |
| Chinese <input type="checkbox"/> | Korean <input type="checkbox"/> | Vietnamese <input type="checkbox"/> |
| Filipino <input type="checkbox"/> | Laotian <input type="checkbox"/> | White <input type="checkbox"/> |

Parent Education Level

(Mark the response that describes the education level of your most educated parent)

- | | | |
|---|---|---|
| Graduate School <input type="checkbox"/> | College Graduate <input type="checkbox"/> | Some College (includes AADegree) <input type="checkbox"/> |
| High School Graduate <input type="checkbox"/> | Some High School <input type="checkbox"/> | Decline to State <input type="checkbox"/> |

Emergency/Health Information

Name/address of student's doctor _____ Phone _____

In case of an accident and we cannot contact you, would you be willing to have the school take your child to the doctor or hospital? **Yes No**

In case of emergency, please name: two responsible adults to whom your child may be sent if you are not home during the day.

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

Does the student have any of the following:

- | | | | | |
|--|--|---------------------------------------|--|---------------------------------|
| Eye problem <input type="checkbox"/> | Wears Glasses/Contacts <input type="checkbox"/> | Hearing Loss <input type="checkbox"/> | Wears Hearing Aid <input type="checkbox"/> | Asthma <input type="checkbox"/> |
| <input type="checkbox"/> Epilepsy <input type="checkbox"/> | Serious Bee Sting Allergy <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Limited Physical Activity <input type="checkbox"/> | |

If so, please explain? _____

Does this pupil have any physical handicaps or limitations?

If yes, please specify: _____

Does this pupil take any long-term medications? If yes, please specify: _____

Does your pupil have any food allergies? Yes No If yes please specify _____

Specific reactions? _____

Does your pupil have any other significant health problems? If yes please specify: _____

Parent/Guardian Signature _____ Date _____