

**Post Falls School District #273
River City Middle School**

Student Registration Form

For Office Use Only	
Date Enrolled _____	
Homeroom Teacher _____	
Grade _____	
Birth Certificate	Y N
Immunizations	Y N
Health Alert	Y N
Directory Release	Y N
Field Trip	Y N
Internet Use	Y N
Court Order	Y N

Legal Last Name _____ Grade _____
First _____ Middle _____
Physical Address _____
Mailing Address _____
Parent's E-Mail Address _____
Home Phone _____ Message Phone _____
Date of Birth _____ Male _____ Female _____
Ethnicity: Caucasian__ Hispanic__ African American__ Asian__ Native American__ Pacific Islander__
Special Services: Has child received any special services? Previously Currently (Please circle one)
Special Education__ Speech/Language__ Occupational Therapy__ Physical Therapy__
Title I__ Gifted/Talented__ 504 Plan__ Other _____

LAST SCHOOL ATTENDED

School Name _____ Phone # _____ Fax # _____
Address _____ City _____ State _____ Zip _____
Last Date of Attendance _____ Parent/Guardian Signature _____
Has this student ever been: Suspended _____ Yes _____ No Expelled _____ Yes _____ No

PARENT/GUARDIAN INFORMATION

Student lives with: _____ (ex: mom/dad, grandparent, guardian, etc.)

Primary Parent _____ Home Phone _____ Cell Phone _____
Address _____ State _____ Zip _____
Employer _____ Work Phone _____
Relationship to Student _____

Secondary Parent _____ Home Phone _____ Cell Phone _____
Address _____ State _____ Zip _____
Employer _____ Work Phone _____
Relationship to Student _____

Legal Guardian (other than parent) _____ Home Phone _____
Address _____ State _____ Zip _____
Employer _____ Work Phone _____ Cell Phone _____

List language(s) spoken in the home: _____

Siblings:

Name _____
School/Grade _____

HEALTH HISTORY

Your signature below authorizes this information to be placed in your child's cumulative file.

Please check the appropriate boxes below that pertain to your child now or in the past. ADHD__ Asthma__

Diabetes__ Seizures__ Cardiac Problems__ Other: _____

Allergies (specify) _____

Current medications: _____

Does your child have a LIFE THREATENING illness or condition that will require a health plan? Yes__ No__

Doctor's Name _____ Phone _____

Parent/Guardian Signature _____ Date _____

EMERGENCY NOTIFICATION CONSENT

In the event of a school or district-wide emergency, I request that the district notify me through personal e-mail or by text. Please use the personal e-mail address or text phone number listed below:

E-Mail Address: _____ Text Phone Number: _____

Parent/Guardian signature _____ Date _____

EMERGENCY INFORMATION

In the event a parent cannot be reached, please list below local relatives or friends we may contact to release your child to in case of illness or school emergency.

1 st Name _____	Phone # _____	Relation to Student _____
2 nd Name _____	Phone # _____	Relation to Student _____
3 rd Name _____	Phone # _____	Relation to Student _____

EMERGENCY CONSENT

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to make any arrangements necessary for the safety of my student. I give my permission for emergency personnel to provide treatment as needed.

Parent/Guardian signature _____ Date _____

NAME / PHOTO / DIRECTORY RELEASE

Permission to have name and/or photo used in newspaper/educational display/website? Yes ___ No ___
Permission to have photo used in Yearbook? Yes ___ No ___
Permission to release directory information to school PTO? Yes ___ No ___

Parent/Guardian signature _____ Date _____

FIELD TRIP PERMISSION

During the school year there are times when our instructional program must be taken out of the classroom and into the community. Rather than asking permission for your child to participate on each occasion, your signature below indicates approval for your child to participate in field trips during the current school year. Through published calendars, newsletters or special notes, we will inform you of times and dates of each field trip prior to the event. This will give you an opportunity to contact your child's teacher if you have questions or choose for your child to not participate.

I grant permission for my child to participate on field trips. Yes ___ No ___

Parent/Guardian signature _____ Date _____

STUDENT INSURANCE

Post Falls School District #273 does make student medical insurance available to families for their individual purchase. Brochures outlining the coverage and premiums are handed out at the beginning of the school year, and are available at the school office after that time. Even with the greatest precautions and the closest supervision, accidents can and do happen at school. They are a fact of life and part of the growing-up process our children go through. Parents, please be prepared to pay for your child's possible medical expenses that may arise should your child be injured at school.

I have read and understand the above information concerning medical insurance coverage.

Parent/Guardian signature _____ Date _____

LEGAL RESTRICTIONS

Are there Legal Restrictions regarding contact with this child? Yes ___ No ___ If yes, a copy of the court order MUST be on file at school. In order to enforce any restrictions on visitation, the school district must be provided copies of legal documents (custody award, restraining order or other court order). Our normal procedure is to contact the custodial parent when individuals attempt to make contact with your child without proper authorization. Please indicate any other procedures you want us to follow. _____

Your child's welfare is our primary concern. Please advise the school immediately of any changes in this information. Your cooperation is appreciated.

Parent/Guardian signature _____ Date _____