

Washington County School District Student Registration Information

Student's <u>Legal</u> Last Name		First and Middle Names			Preferred Name	
Gender	Birth Date	Country of Birth	Grade	Social Security Number (Optional)	Home Telephone	
Home Street Address			City	Zip Code		
Mailing Address (if different)						
Email Address (Secondary schools: all information will be sent electronically including report cards)				Secondary Schools Only: <input type="checkbox"/> I prefer to have information mailed to my home and understand that I will be charged a fee of \$5.00 per year for this service.		
My student has special needs (i.e. Special Education, IEP, medical, 504, etc.): <input type="checkbox"/> Yes <input type="checkbox"/> No						
Father's Name		Place of Employment		Work Telephone	Cell Phone	
Mother's Name		Place of Employment		Work Telephone	Cell Phone	
Guardian's Name/Relationship (if other than natural parent)		Place of Employment		Work Telephone	Cell Phone	
Emergency Contact Name (to call if parent/guardian cannot be reached)			Relationship to Student		Emergency Telephone	
Are you Hispanic/Latino/Spanish origin? <input type="checkbox"/> No, not Hispanic/Latino/Spanish origin <input type="checkbox"/> Yes, Hispanic/Latino/Spanish origin						
Select your race: (You must select one, even if you answered "yes" on the above question. You may select more than one if applicable.)						
<input type="checkbox"/> American Indian or Alaska Native (Tribe: _____)		<input type="checkbox"/> Black or African American		<input type="checkbox"/> Asian		<input type="checkbox"/> White
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander						
Please complete all information:						
1. What was the first language the student learned to speak? _____						
2. List all languages spoken or understood by the student. (Please do not include languages learned through foreign language programs.) _____						
3. List all languages spoken in the home. (Please do not include languages learned through foreign language programs.) _____						
4. In what language do you need to receive communication from the school? _____						
5. Date entered U.S. school system (m/d/yyyy) _____						
Previous School Attended (Name, Address, City and Zip):						
List persons, with phone number, other than parent/guardian who may check student out of school:						

I acknowledge that I have reviewed and been given a copy of the Washington County School District Schools Policy and Grounds for Suspension and Expulsion as located in School Handbook. (_____ Initial)

I certify that the above student is living with a natural parent or court-ordered guardian, and resides permanently in the attendance area of this school.

Signature of Parent or Legal Guardian (Relationship to Child)

Date

The Washington County School District does not discriminate on the basis of race, color, national origin, or disability in any educational program.

Information on this document is classified as private in accordance with Government Records Management Act (Utah Code 63-2-302).

WCSD Form 901

Revised 09/2013

For School Use Only:

School _____ Entry Code _____ Entry Date _____ Birth Certificate Immunization
 Student ID# from previous school _____ Other _____ Bus Number _____

UTAH DEPARTMENT OF HEALTH
UTAH IMMUNIZATION PROGRAM &
UTAH STATEWIDE IMMUNIZATION INFORMATION SYSTEM

PERMISSION TO SHARE IMMUNIZATION INFORMATION

Student Name _____

Student ID Number _____ Student DOB _____

School _____ School District _____
(if applicable)

Utah 53A-11-301 requires documentation of immunizations for school attendance.

The Utah Department of Health maintains a voluntary, confidential record system to assist parents/guardians, health care providers, and schools in documenting your child's immunizations. This record system is called the Utah Statewide Immunization Information System (USIIS). Allowing your child's school to share your child's immunization history with USIIS will aid you, your child's health care provider, and the school to determine which immunizations your child has received and which may still be needed.

- I give my permission for the school to share my child's/legal dependent's immunization information with USIIS.

- I do not give permission for the school to share my child's/legal dependent's immunization information with USIIS.

Print Name of Parent or Guardian

Signature of Parent or Guardian

Date

Approved by the
Utah Department of Health
Modifications are not permitted.

USIIS Form 7 10/2006

Departamento de Salud del Estado de Utah

Programa de Inmunización de Utah & Sistema de Información de Inmunización de Utah

PERMISO PARA COMPARTIR INFORMACION DE INMUNIZACION

Nombre de estudiante _____

Número de identificación del estudiante _____ Grado del Estudiante _____

Escuela _____ Distrito Escolar _____

Utah 58A-11-301 requiere documentación de inmunizaciones para la asistencia a la escuela.

El Departamento de Salud de Utah mantiene un sistema de información, confidencial y voluntario para ayudar a padres/representantes, proveedores de salud, y las escuelas a documentar las inmunizaciones de niño. Este sistema de información es llamado Sistema de Información de Inmunización de Utah (USIIS siglas en ingles). Permitiendo que la escuela de niño comparta la historia de la inmunización de niño con USIIS la ayudará a usted, a su proveedor de salud del niño, y la escuela a determinar cuál inmunizaciones su niño ha recibido y cuales vacunas necesita.

Doy mi permiso a la escuela a compartir la información de inmunizaciones de mi hijo o de mi representante legal con USSIS

Yo no doy mi permiso a la escuela a compartir la información de inmunizaciones de mi hijo o de mi representante legal con USSIS

Nombre de Padre o Guardián

Firma de Padre o Guardián

Fecha

CHILD'S NAME	TEACHER
HOME ADDRESS CITY	HOME PHONE
FATHER'S NAME	WORK/CELL PHONE
MOTHER'S NAME	WORK/CELL PHONE
EMERGENCY CONTACT	PHONE
EMERGENCY CONTACT	PHONE
SIBLINGS ENROLLED AT HES	E-MAIL ADDRESS
HEALTH CONCERNS	
OTHER CONTACTS ABLE TO PICK UP KIDS	
FOR REUNIFICATION ONLY: DATE: TIME: SIGNATURE:	

Hurricane Elementary

Student Information Questionnaire McKinney-Vento Eligibility Washington County School District

This questionnaire is intended to address the McKinney-Vento Education Assistance Improvement Act 42 U.S.C. 11435. **The answers to this questionnaire help determine the services the student is eligible to receive.**

1. Is your current address a temporary living arrangement? _____ Yes _____ No
2. Is this temporary arrangement due to loss of housing or economic hardship? _____ Yes _____ No

If you answered YES to either of the above questions, please complete the remainder of this form.

If you answered NO to both questions, you may stop here.

Which of the situations below apply to the student?

- H1 Student is sharing a residence with one or more families temporarily.
- H2 Student is living in a motel or hotel.
- H3 Student is living in a shelter (domestic violence, emergency, or transitional housing units).
- H4 Student is living in a car, park, campground, or public place.
- H5 Student is living in a place without adequate facilities (running water, heat, electricity).
- H6 Student is seeking enrollment "without" an accompanying parent (not in foster care).

Student is "physically" living with a parent or guardian in the above situation? _____ Yes _____ No

Yes = Accompanied

No = Unaccompanied

- **IF a false claim is made about your living situation, enrollment may be affected.**
 - ***Please notify the school if your living status changes.**
-

Student name _____

School _____

Date _____ Grade _____ Gender _____

Parent signature _____

STUDENT HEALTH INFORMATION

Student:	Today's Date:
School:	Student Date of Birth:
Physician/Clinic:	Date of last physical exam:
Eye Examiner:	Date of last eye exam:

EMERGENCY CONTACTS

Mother:	Father:
Mother's Home Phone:	Father's Home Phone:
Mother's Work Phone:	Father's Work Phone:
Mother's Cell Phone:	Father's Cell Phone:
Other Emergency Contact & Phone:	

Parent/Guardian Consent and Agreement for Emergencies:

As parent/legal guardian, I give consent to have my child receive first aid by school staff, and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above to act on my behalf until I am available. I agree to review and update this information whenever a change occurs.

Date: _____ Parent/Legal Guardian: _____

HISTORY OF SPECIAL HEALTH CARE NEEDS

ADHD:
AUTISM:
ALLERGIES:
ASTHMA:
DEPRESSION/ANXIETY:
DIABETES:
DISABILITIES:
HEARING:
HEART:
MOBILITY:
SEIZURES:
URINARY:
VISION:
OTHER:

Is your child taking medication? Yes No Medication(s): _____

Is medication to be administered during school? Yes No (If yes, confer with staff for instructions.)

VISION SCREENINGS *(For school personnel use only)*

DATE											
GRADE	K	1	2	3	4	5	6	7	8	9	10
PASS											
REFER											
TREATMENT											

Utah state law mandates vision screenings in grades K, 1, 3, 5, 7, & 10. 10th graders are screened in Drivers Ed.

- PASS = can see according to the standard set by the state of Utah.
- REFER = child has been referred for eye examination.
- TREATMENT: N=no treatment required G=glasses/contacts CB=sit close to chalk board
 M=being monitored P=patch S=surgery required

FAX TO SCHOOL NURSE IF SPECIAL HEALTH CARE NEEDS EXIST * TO BE KEPT CONFIDENTIAL FOR OFFICIAL USE ONLY