· *Middle School* · *High School* · *Central Elementary* · *Linwood Elementary* X *GSRP*

PINCONNING AREA SCHOOLS
REGISTRATION FORM

Today's Date: _____ **Entering Grade: Preschool**

Student Name: _____
Last First Middle

Date of Birth: _____ **Birth Place:** _____
Month/Day/Year City/ State

Phone Number: _____
Area Code Phone Number

Address: _____
Street City Zip Code

Between what roads/crossroads: _____

County _____

Expected Graduating Year: _____ **Gender:** Male Female

Ethnicity: Hispanic or Latino _____Yes _____No
_____American Indian or Alaska Native _____White/Non Hispanic _____ Asian American
_____Native Hawaiian or Pacific Islander _____Black or African American

Child Resides with: (please check one)
_____both parents _____mother/stepfather _____father/stepmother _____mother only
_____father only _____legal guardian _____foster home _____relative
_____divorced, joint custody (copies of court order required)

Parent/Guardian Information:

Father/Guardian Name_____ **Mother/Guardian Name:** _____
For School Messenger and Skyward notifications:
Email Address: _____ **Email Address:** _____

Work Place:_____ **Work Place:** _____

Work Phone Number: _____ **Work Phone Number:** _____

Cell Number: _____ **Cell Number:** _____

Parent Living Elsewhere: _____ **Relationship**:_____

Address: _____
Number/Street PO Box City State Zip Code

Previous School: _____
School Name
Previous School Address: _____
Street Number Street City State Zip Code

*******PLEASE TURN OVER AND COMPLETE THE BACK*********

SERVICES YOUR STUDENT RECEIVED AT PREVIOUS SCHOOL: (check all that apply)

____Speech _____Special Education _____Social Worker ____Title 1 ____ 504

Additional Information *(if needed)* _____

Has your child been suspended by a principal, hearing officer or Board of Education? _____
If Yes, what was the date of suspension/expulsion and what was the reason:

_____

_____

Emergency Medical Conditions/Problems: Check ALL that apply

___nothing known	___iodine allergy	___wears glasses
___medical waiver	___multi-allergy	___bee sting
___rheumatic	___epileptic	___asthma
___cardiac	___contact lenses	___nose bleeds
___hemophiliac	___special blood condition	___no medication, religious
___diabetic	___sulpha allergy	___check health card
___aspirin allergy	___muscle weakness	___attention deficit disorder
___penicillin allergy	___headaches	___hearing problems

___takes medication regularly (please indicate which medication and how often)

_____

Does your child have Food Allergies? ____ Yes _____ No *(if dietary adjustments needed at school, please ask for form)*
Explain:_____

_____

Other children who reside in the home:

Name	Birthdate	Grade		
_____	_____	_____	___natural sibling	___step sibling
_____	_____	_____	___natural sibling	___step sibling
_____	_____	_____	___natural sibling	___step sibling
_____	_____	_____	___natural sibling	___step sibling

For Kindergarten Students Only:

What was your child's primary form of care in the year before entering kindergarten this year?

☐ Great Start Readiness Program (GSRP)	☐ Head Start	☐ Child Care – Home Based
☐ Child Care – Center Based	☐ Tuition-Based Preschool	
☐ Early Childhood Special Education Classroom	☐ Young 5's/Developmental Kindergarten	
☐ Family/Relative Care	☐ No Prior Care/Program	

What is the name of the pre-school or child care provider? _____

What were the reasons you either sent or didn't send your child to a preschool/prior care experience?

_____

I affirm, that as the parent/legal guardian, all information provided above is true and accurate, and that my child and I reside at the listed address. I understand any false information provided by me, may subject me to legal penalties for perjury.

_____ _____

Parent/Guardian Signature **Date**