

# Haverford Twp School District

## STUDENT REGISTRATION FORM

School Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### PLEASE COMPLETE THE FOLLOWING VITAL INFORMATION

Student Last Name	First Name	Middle Name	Nick Name	Entry Grade	Sex
Social Security No. *	Birthdate	Birth city/state		Home Phone ( ) Check if this # is unlisted _____	

Have you previously graduated from another high school? \_\_\_\_\_ Ethnic Category (Check One)

Name of School \_\_\_\_\_  I-American Indian  B-Black  A-Asian

Address \_\_\_\_\_  W-White  H-Hispanic  Multi-Racial

Home Language \_\_\_\_\_ **CIRCLE ALL GRADES YOUR STUDENT ATTENDED SCHOOL IN THE U.S.A.**

K 1 2 3 4 5 6 7 8 9 10 11 12

### PRIMARY HOUSEHOLD INFORMATION: Name(s) of person(s) WITH WHOM STUDENT IS LIVING.

Use page 2 to supply information concerning other parent(s) and/or guardian(s).

Living With: (Check one)

1-Both Parents  2-Mother Only  3-Father Only  4-Self  5-Agency

6-Guardian  7-Mother/Stepfather  8-Father/Stepmother  9-Stepfather/Stepmother  0-Other(Specify)

Last Name Title(circle): Mr. Mrs. Miss Ms.	First Name	Work Place/City	Bus. Phone ( ) Cellular/Pager: ( )	Ext.
Last Name Title(circle): Mr. Mrs. Miss Ms.	First Name	Work Place/City	Bus. Phone ( ) Cellular/Pager: ( )	Ext.

Parent/Guardian Mailing Address	City	Zip
Parent/Guardian Street Address (if different than above)	City	Zip

### EMERGENCY INFORMATION: List two local persons (other than yourself) usually available during the school day who have agreed to care for and provide transportation for your student if he/she becomes ill or injured and you cannot be reached. We attempt to contact parents first.

Name	Relationship to Student	Address	Daytime Phone ( )	Ext.
Name	Relationship to Student	Address	Daytime Phone ( )	Ext.

Enter the name of your family physician who may be contacted by school staff member when parent cannot be reached and medical assistance is indicated. Please note that when Fire Department Medical Unit responds they will contact available emergency room physician who may in turn contact your family physician. If you have no family doctor, you can state any local physician.

Family Doctor	Phone Number ( )	Ext.
Family Dentist	Phone Number ( )	Ext.

We occasionally receive requests from news media to take photographs or videotape in the classroom. Please indicate below whether or not you agree to allow your child to appear in media products.

Yes, I agree to allow my child to be photographed or videotaped by the media.

No, I do not want my child to be photographed or videotaped by the media.

\* Disclosure of a student's social security number is voluntary. The number is used as a student identifier. It will be used solely for state and local statistical purposes.

OVER PLEASE

Student Name: \_\_\_\_\_

**SECOND HOUSEHOLD INFORMATION:** Name of Parent(s) and/or Guardian(s) OTHER than those listed under Primary Household Information.

Last Name	First Name	Relationship to Student	Work Place/City	Bus. Phone No.	Ext.
Last Name	First Name	Relationship to Student	Work Place/City	Bus. Phone No.	Ext.
Home Phone	Check if Unlisted	Should school mailings be sent to this household also?		Yes	No
Parent/Guardian Mailing Address			City	State	Zip
Parent/Guardian Street Address			City	State	Zip

Any Additional Arrangements:

**PREVIOUS SCHOOL INFORMATION:**

Number of previous schools attended \_\_\_\_\_

Last School Attended	Grade	Address of Former School, City, State, Zip
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Has your child ever attended the \_\_\_\_\_ School District?  Yes  No

If yes: School Attended \_\_\_\_\_ Year(s) Attended \_\_\_\_\_

Has your child ever been enrolled in a special program? Yes  No  If yes, specify:

**CIRCLE THE GRADE LEVEL BELOW OF OTHER CHILDREN IN THE HOME**

PRE-KINDGN    K DGN    1    2    3    4    5    6    7    8    9    10    11    12

**RESIDENCY VERIFICATION:** The residency information provided on this form is true and accurate as of this date. I understand that falsification of an address or the use of any other fraudulent means to achieve an enrollment or assignment shall be cause for revocation of the student's enrollment and assignment to the school serving the home attendance area.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**OFFICE USE ONLY**

Student ID#	Dist Stu #	School Entry Date	Entry Code	Att. Code	F.T.E.
Faculty #	Room #	Faculty Name			Birth Certificate <input type="checkbox"/> Yes <input type="checkbox"/> No
Placement Reason	AM bus Route	AM Bus Stop	PM Bus Route	PM Bus Stop	Records Requested:

**DATE OF IMMUNIZATION & STATUS**

DPT/DTd		POLIO		MEASLES		RUBELLA		MUMPS	
St	Mo Day Year	St	Mo Day Year	St	Mo Day Year	St	Mo Day Year	St	Mo Day Year