Ripley Central School
PO Box 688, 12 North State Street
Ripley, NY 14775-0688
Ph: 716-736-2631

Student Registration Form

2018-2019

Office Use Only
Student ID# ____________
Bus # ________________
Locker # ______________

STUDENT(S)

Ethnic Origin:
American Indian or Alaska Native (I), Asian (A), Black or African American (B), Hispanic or Latino (H), White (W)

Name: ______________________ Date of Birth: __________ Gender: ___ Race ___ Grade: ___
Name: ______________________ Date of Birth: __________ Gender: ___ Race ___ Grade: ___
Name: ______________________ Date of Birth: __________ Gender: ___ Race ___ Grade: ___
Name: ______________________ Date of Birth: __________ Gender: ___ Race ___ Grade: ___

If more space is needed, continue on back.

Home Address: ______________________ Home Phone: __________
Mail Address: ______________________

CONTACT 1 - *A parent or guardian residing with the student*
Name: ______________ Relationship: ________ Email: ______________
Phone (Home): __________ Phone (Work): __________ Phone (Cell): __________ Call Order(1-5) ____

CONTACT 2 - *A parent or guardian residing with the student*
Name: ______________ Relationship: ________ Email: ______________
Phone (Home): __________ Phone (Work): __________ Phone (Cell): __________ Call Order(1-5) ____

CONTACT 3 - *A parent or guardian* not *residing with the student* Allowed to pick up student?* ____
Name: ______________ Relationship: ________ Email: ______________
Mailing Address: ______________________ Receive Mail?: ____ Joint Custody?: ____
Phone - Home: __________ Work: __________ Cell: __________ Call Order(1-5) ____

Emergency Contact 1 Allowed to pick up student?* ____
Name: ______________________ Relationship: __________
Phone #1: ______________________ Phone #2: __________ Call Order(1-5) ____

Emergency Contact 2 Allowed to pick up student?* ____
Name: ______________________ Relationship: __________
Phone #1: ______________________ Phone #2: __________ Call Order(1-5) ____

Doctor
Name: ______________________ Practice Name: ______________________
Phone: ______________________ Fax: ______________________

Dentist
Name: ______________________ Practice Name: ______________________
Phone: ______________________ Fax: ______________________

GUARDIAN ALERT - *Do Not Release* my child to: * ______________________

*Current custody paperwork must be on file with the district.

Signature of Parent/Guardian: ______________________

over

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

RIPLEY CENTRAL SCHOOL RESIDENCY QUESTIONAIRE

Please list your current address: ____

Please lit your previous address: ____

School previously attended: ____

Where is the student currently? (Please check ONE)

________ In a shelter

________ With another family or other person because of loss of housing or as a result of economic hardship.

________ In a hotel/motel

________ In a car, park, bus, train, or campsite

________ Other temporary living situation (please describe): ____________________________

________ In a permanent housing

HEALTH INFORMATION

Does the student have health insurance? YES______ NO______

Health Insurance provider: ____

List all allergies: ____

List all medications taken at home and/or at school: ______________________________

____

Other medical information (be specific): ______________________________

____

Sunscreen:

I agree to provide and give permission for the use of FDA approved sunscreen (Coppertone Sport SPF 30 or greater) on my child for avoiding overexposure to the sun. Check the box if you **DO NOT** want sunscreen used. ☐

____

Parent Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION TO RIPLEY CENTRAL SCHOOL

Permission is hereby given to: ____
(SCHOOL STUDENT IS COMING FROM)

____
(Prior School's Address and Zip Code)

release pertinent information including scholastic grades, achievement scores, medical records (immunization records, psychiatric, psychological, etc.), special education (I.E.P., etc.), and attendance concerning your student(s) to Ripley Central School.

Name____________________________________ DOB________________ Grade__________

Name____________________________________ DOB________________ Grade__________

Name____________________________________ DOB________________ Grade__________

Please send the above stated information to:

Guidance Office
Ripley Central School
PO Box 688
12 North State Street
Ripley, NY 14775-0688

Phone (716) 736-2631 Ext. 1191
Fax (716) 736-6210

____
Parent/Guardian's Signature

____
Street Address

____
City, State, Zip

____
Authorized School Signature

____
Date of Registration

New and Transfer Student Health History Form

Child's Full Name____
Last First Middle

Male_____ Female_____ Birth Date ___________________________

Health Conditions-Please check any of the following that your child currently has or has had in the past.

_____Abnormal Spine Curvature (Scoliosis, etc)
_____ADD/ADHD
_____Allergies or Hay fever
_____Anemia
_____Arthritis
_____Asthma/Wheezing
_____Behavior Problems
_____Birth/Congenital Malformation
_____Cancer, Type____________
_____Chickenpox, Date_________
_____Hepatitis
_____Chronic Diarrhea or Constipation
_____Cystic Fibrosis
_____Depression
_____Diabetes
_____Eczema
_____Emotional Disorders
_____Frequent Headaches
_____Frequent sore throat/infections
_____Heart Disease, type______________
_____Kidney Disease, type __________
_____Measles
_____Migraine Headaches
_____Mumps
_____Meningitis or Encephalitis
_____Nervous twitches/tics
_____Rheumatic Fever
_____Seizures or Epilepsy
_____Sickle Cell Disease
_____Stool Soiling
_____Substance abuse (alcohol/drugs)
_____Suicide Attempt
_____Toothaches/dental problems
_____Tuberculosis (TB)
_____Urinary Tract Infections
_____Urinary accidents (night/day)
_____Other Chronic Health Problem

Explain checked items____
____
____

Any condition that would prevent full participation in educational programs (including physical education) requires physician documentation/orders before modifications can be considered. See your School Nurse for further information.

Allergies- Please list and describe allergies/reactions to:
Medication/Drugs___________________________Treatment_______________
Foods/Plants/Animals/Other__________________Treatment_______________
Bee Stings/Insect Bites______________________Treatment _______________

If your child requires medication for treatment of an allergic reaction during the school day, see your School Nurse for further information.
Injuries and Illnesses- Please list any severe injuries or illnesses;
Illness/Injury Date(s) Hospitalized___
____Yes No_____
____Yes No_____
____Yes No_____

Vision and Hearing (Check all that apply)
_____Frequent Ear Infections (3 or more per year)
_____Hearing Loss Circle one - Right / Left / Both
_____P.E. Tubes (Date placed _________ Still in Place? Yes / No)
Last Hearing Exam_____________________
_____Vision Problems
_____Wears Glasses/Contacts (Circle one) Reason___________________
Last Vision Exam_____________________

Additional Information:

Does your child see the doctor regularly for a chronic medical condition? (Circle One) Yes / No
If yes, please complete the following.
What is the medical condition?____
Doctor's Name_________________________________Phone____________________
What medications are given daily?____
What medications are given frequently, but not daily?______________________________
When did your child last see the doctor for this condition?___________________________

If your child requires medication during the school day (prescription or over the counter), see your School Nurse. Certain forms must be completed for medication to be dispensed during school hours.

Doctor's Name_______________________________________ Phone number______________
Dentist's Name______________________________________ Phone number______________
Date of last physical exam___________ Doctor/Clinic (If different from above)____________________
Date of last dental exam_____________ Dentist/Clinic (If different from above)____________________
Immunizations received at____
This child is usually: Very Active_____ Normally Active _____ Passive_____
Do you have any concerns about how your child gets along with other children?_______________
____
Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly__________________
____
____
____

Has your child ever been evaluated for:
______Speech/Language Impairment
______OT/PT (Occupational or Physical Therapy)
______LD/SLD (Learning Disability/Specific Learning Disability)
______CD (Cognitive Disability)
______MD (Multiple Disabilities)
______ED (Emotional Disturbance)

Other household members:
Name____Relationship______________Age_________
Name____Relationship______________Age_________
Name____Relationship______________Age_________
Name____Relationship______________Age_________
Name____Relationship______________Age_________
Name____Relationship______________Age_________
Form completed by____
Relationship to child____

I (do/do not) give my permission for the School Nurse to share this information as needed for the benefit of my child's health and educational needs, except for ___________________________
____
____Date____________ Phone___________

Signature ______________________________________

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please sign and give the form to your school nurse to avoid delays.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I ______________________________ authorize my child's healthcare provider(s) listed below to release my child's

______________________________medical records to **Ripley Central School District's** medical officer, physical (PT), occupational (OT), and speech therapists (ST), School Psychologist, School Social Worker and/or school nurse:

Name ______________________________Phone ______________FAX______________

Name ______________________________Phone ______________FAX______________

Name ______________________________Phone ______________FAX______________

Name ______________________________Phone ______________FAX______________

The healthcare provider may disclose the following protected health information: (check all that apply)

□ Immunizations

□ Health Appraisals

□ Past/Current Medical Conditions and Its Impact on Attendance, School Programming, and/or PT, OT, ST, Psych Testing needs.

□ Other ______________________________

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

□ To develop care or therapy plans for routine and emergent school management

□ To design appropriate educational programs

□ To assess the impact of the medical condition(s) on school programming and/or attendance

□ To share school observations/concerns surrounding behavior

□ To assess a medical basis for modification of transportation and/or home tutoring

□ Medication delivery and/or therapy prescriptions for PT, OT, ST, Behavior or other medical conditions.

□ At patient's request with no specified purpose

□ Other ______________________________

Please select one:

This authorization is valid for the entire academic school year 20___-20___

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.

I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

Date:__________Signature of Parent/Guardian: ______________________________Relationship: ______________

Information Regarding Special Educational Needs

Name of student: ______________________________

Name of parent/guardian: ______________________________

Has your child ever been identified as having special educational needs?

Yes No

If yes...

Please briefly describe the needs (type of need or disability, impact on education, etc.):

____

____

____

____

How were your child's needs met at the previous school district?

______ Individualized Education Program (IEP)

______ 504 Plan

______ Other ______________________________

In addition, please complete a social history form (provided by the guidance secretary) to give us additional information about your child's background and needs.