

Central Fulton School District Registration

Today's date: _____ Student's grade: _____ Sex: M ___ F ___

Student's Full Name: _____

Home phone number: _____

Address: _____

Place of birth, City and State: _____

Mother's Name: _____ Work phone number: _____

Occupation: _____ Cell phone number: _____

Education: _____ Birthplace: _____

Father's Name: _____ Work phone number: _____

Occupation: _____ Cell phone number: _____

Education: _____ Birthplace: _____

Student lives with: (Circle one) Both Parents Mother Father Other (please specify)

Guardian Name: _____ Phone number: _____

Custody Papers? YES OR NO

Brothers and Sisters:	Name	Date of birth
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Emergency Contacts: In the event parents cannot be reached.

#1 Name: _____ Relationship: _____
Telephone number: _____

#2 Name: _____ Relationship: _____
Telephone number: _____

The school nurse has Tylenol, Antacid, and Sore throat lozenges available. Is your child permitted to have these?

Tylenol (Please circle one) YES NO

Antacid (Please circle one) YES NO

Sore throat lozenge (Please circle one) YES NO

The nurse also has topical creams available for cuts, burns, insect bites and stings. Is your child permitted to have these? YES NO

Signature of Parent or Guardian: _____

Please complete the health history on other side.

HEALTH HISTORY

Name of student's doctor: _____ Phone: _____

Does your child have any of the following? Please mark all that apply.

___ Allergies: list all allergies _____

___ Bee Sting Allergy: list medications _____

___ Asthma: list medications _____

___ Diabetes Type I or Type II: list medications _____

___ Seizures: list medications _____

___ Heart murmur or other heart condition _____

___ Arthritis/Rheumatic Disease _____

___ Bleeding disorder _____

___ Cerebral Palsy _____

___ Cystic Fibrosis _____

___ Sickle Cell _____

___ Spina Bifida _____

___ Tourette's Syndrome _____

___ Autism: list treatments _____

___ ADHD: list medications _____

___ Eating Disorder _____

___ Vision problems _____

___ Hearing problems _____

___ No health problems

Please list any other medical conditions, physical defects, serious illnesses, operations or other medications taken regularly?

