Wellpinit School District #49

P.O.Box 390, 6270 Ford Wellpinit Rd. Wellpinit, WA 99040, (509) 258-4535

STUDENT REGISTRATION FORM

STUDENT NAME:____
(Please Print) Last Name First Middle Sex (F-M)

BIRTH DATE: ____________________GRADE LEVEL______________SS#___________/___________/___________

ETHNIC
(Circle One) AMERICAN INDIAN CAUCASIAN BLACK HISPANIC ASIAN

MAILING ADDRESS:____
Street/Box City State Zip Code

STUDENT'S HOME PHONE:_______________________ DAY PHONE:_______________________

PARENT/GUARDIAN INFO:

Guardian # 1 Circle one = (Mother) (Father) (Grand Parent) (Legal Guardian) (Other)	**Guardian # 2** Circle One = (Mother) (Father) (Grand Parent) (Legal Guardian) (Other)
(1) First Name:	(2) First Name:
(1) Last Name:	(2)Last Name:
(1) Employer:	(2) Employer:
(1) Work Phone:	(2) Work Phone:
(1) E-Mail Address:	(2) E-Mail Address:

EMERGENCY CONTACT INFORMATION:

Contact Person # 1 Name:	**Contact Person # 2 Name:**
(1) Home Phone:	(2) Home Phone :
(1) Work Phone :	(2) Work Phone :

Other siblings enrolled in Wellpinit School:

1. ______________________ Grade ______ 2. ______________________ Grade ______

3. ______________________ Grade ______ 4. ______________________ Grade ______

BUS STOP INFORMATION:

Was your child enrolled in Wellpinit School at the end of last school year?	**YES**		**NO**	
If NO, Has your child attended Wellpinit School before?	**YES**		**NO**	
If transferring: **Name of Previous school attended:**		**City / State:**		

SIGNATURE OF
LEGAL PARENT/GUARDIAN:______________________________**DATE:**__________

<<<< TURN PAGE OVER FOR MEDICAL CONSENT FORM >>>>

WELLPINIT SCHOOL DISTRICT #49

P.O. Box 390, Wellpinit, WA. 99040 (509-258-4535)

CONSENT FOR MEDICAL TREATMENT (ILLNESS / ACCIDENT)

Student Last Name **First Name** **MI** **SS#** **Birthday**

If this child has any medical problems which may require special attention, leave special instruction and provide the school with medicine (must be labeled with doctor signature) if needed. (Example, Bee Sting Kits, Inhaler, Personal Tylenol, Benadryl.) **Physician's Authorization Form** will be required for medications at school.

ASTHMA EPILEPSY SEVERE ALLERGIES HEART PROBLEM

OTHER CONDITION (LIST)____

ALLERGY TO MEDICATIONS (LIST)____

MEDICATION AS TAKEN____

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M E D I C A T I O N S

PRESCRIPTIONS / OVER THE COUNTER MEDICATIONS REQUIRE A PHYSICAIN'S AUTHORIZATION FORM.

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In case of illness or accident that is not serious in nature, but the student would be better off at home, the school may contact:

Parents at home(phone number)__________________**Parents work number**________________**Or**________________

or call _______________At phone number___________________Who has agreed to watch my child if I cannot be reached.

Or call________________At phone number_________________ Who has agreed to watch my child if I cannot be reached.

In case of serious illness or accident, the school shall attempt to call parents first. If a parent cannot be reached, I authorize the school to arrange transportation to an emergency medical facility for my child.

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I, (We),_____________________and (_____________________), hereby state that I am (We are) the natural parent(s) or legal guardian(s) of the above child. I authorize any employee of the Wellpinit School District, to consent to any minor or emergency medical treatment WHEN THE NEED FOR SUCH TREATMENT IS IMMEDIATE, AND THE EFFORTS TO CONTACT ME (US) ARE UNSUCCESSFUL.

Your preference of hospital or emergency medical facility to which your child should be transported:

HOSPITAL:___________________________________ PHYSICIAN/NUMBER:_____________________________________

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LEGAL PARENT/ GUARDIAN SIGNATURE **DATE**

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