Deerfield Elementary School

Registration

For School Use Only:

STN # ______
Teacher: ______
Book Rent: ______
Owe: ______
Entry Date: ______
Withdrawal Date: ______

Student Information:

Grade: ______

First Name: ______ Middle Name: ______
Last Name: ______
Address: Street ______
City, IN: ______ Zip ______
Home/Cell Phone: ______ Text Capable? Yes No

Age: ______ Sex: M F Social Security Number: ______
Date of Birth: ______ City and State of Birth: ______

Race Category: (Circle)
1~Hispanic/Latino
2~Not Hispanic/Latino

~AND~

Ethnic Category: (Circle)
1~American Indian or Alaskan
2~Black, Non-Hispanic
3~Asian or Pacific
4~ Spanish or Hispanic
5~ White, Non-Hispanic
6~Multiracial

Name of Parents or Guardians Who Live with Child:

Name: ______ Relationship: ______
Occupation: ______ Place of Employment: ______
Email Address: ______ Work Phone: ______
Cell/Alt Phone: ______ Text Capable? Yes No

Name: ______ Relationship: ______
Occupation: ______ Place of Employment: ______
Email Address: ______ Work Phone: ______
Cell/Alt Phone: ______ Text Capable? Yes No

Name of Divorced or Separated Parent Who is NOT Living with Child:

Name: ______ Relationship: ______
Occupation: ______ Place of Employment: ______
Email Address: ______ Work Phone: ______
Cell/Alt Phone: ______ Text Capable? Yes No

Brother and Sisters Living at Home & Their Ages:

Name:	Age:	Name:	Age:

Additional Information

Prior School Experience / New Students

Former School: ______________________ Phone: ________________

Address: ____

Has your child ever attended *Randolph Central School Corporation?* Yes No

Special School Services ~ Check if your child has been in the following:

Title 1 ____________ Speech ____________ Special Education ____________

Does your child have an IEP? YES NO

District of Residence

County of Residence:

- [ ] Randolph
- [ ] Jay
- [ ] Delaware
- [ ] Other ______________________

If Randolph, which zone do you live in:

- [ ] Randolph Central - Deerfield
- [ ] Randolph Central - Baker/Willard
- [ ] Randolph Eastern (Union City)
- [ ] Randolph Southern (Lynn)
- [ ] Monroe Central (Parker/Farmland)
- [ ] Union (Modoc)

*If you checked any box other than Randolph County and Deerfield, please fill out the appropriate transfer form to be approved by the superintendent. Thank you!

Early Dismissal

In the event of an early dismissal, I wish my child to:

- [ ] Go home as usual.
- [ ] Be picked up by one of the individuals listed on the following contact sheet.

Babysitter & STEPS Information:

If your child will get off the bus at a babysitter's regularly, please provide details:

Name: ______________________ Phone: ________________

Address: ______________________ Bus Number: ________________

If your child will be attending the STEPS afterschool program, please state when they are to attend:

- [ ] Every Tuesday
- [ ] Every Thursday
- [ ] Will call school when they are to attend

Parent or Legal Guardian's Signature ______________________ *Date:* ____________

Deerfield Elementary School

Contact List

Student Name: ______________________________________ Grade: ______________________

Dismissal Policy

The school is responsible for the safety and well-being of your child. In the event students need to be dismissed early or sent home due to illness, they will only be released to a person authorized by a parent. Please list below anyone you wish to authorize to pick up your child. The person(s) that you authorize to pick up your child must show a form of identification if they are not known by the principal or designee. Please understand that you may not be able to reach us by phone in the event of an emergency. It is important that this form is completed correctly and updated when necessary.

School Messenger Broadcasts

Randolph Central School Corporation uses School Messenger telephone broadcasts to relay information regarding emergencies and announcements to families.

Contact Information

In the event you cannot be reached, list contacts in the order in which you prefer them to be called. (For example: we will try to contact the first person listed first, etc) **YOU DO NOT NEED TO LIST YOURSELF.**

NAME: ____

HOME PHONE: ____________________________ RELATIONSHIP: ______________________

WORK PHONE: ____________________________ CELL PHONE: ______________________

ADDRESS: ____

This contact is allowed to: (please check all that apply)

- [ ] be called and pick up student in the event of early dismissal.
- [ ] be called and pick up student if they are sent home due to illness.
- [ ] be called and pick up student due to behavior issues.
- [ ] pick up student after school.
- [ ] have report cards or other documents mailed to them. (use for non-custodial parents)

NAME: ____

HOME PHONE: ____________________________ RELATIONSHIP: ______________________

WORK PHONE: ____________________________ CELL PHONE: ______________________

ADDRESS: ____

This contact is allowed to: (please check all that apply)

- [ ] be called and pick up student in the event of early dismissal.
- [ ] be called and pick up student if they are sent home due to illness.
- [ ] be called and pick up student due to behavior issues.
- [ ] pick up student after school.
- [ ] have report cards or other documents mailed to them. (use for non-custodial parents)

Please list additional contacts on reverse.

Additional Contacts

NAME: ____________________
HOME PHONE: ____________________ RELATIONSHIP: ____________________
WORK PHONE: ____________________ CELL PHONE: ____________________
ADDRESS: ____________________

This contact is allowed to: (please check all that apply)

- [ ] be called and pick up student in the event of early dismissal.
- [ ] be called and pick up student if they are sent home due to illness.
- [ ] be called and pick up student due to behavior issues.
- [ ] pick up student after school.
- [ ] have report cards or other documents mailed to them. (use for non-custodial parents)

NAME: ____________________
HOME PHONE: ____________________ RELATIONSHIP: ____________________
WORK PHONE: ____________________ CELL PHONE: ____________________
ADDRESS: ____________________

This contact is allowed to: (please check all that apply)

- [ ] be called and pick up student in the event of early dismissal.
- [ ] be called and pick up student if they are sent home due to illness.
- [ ] be called and pick up student due to behavior issues.
- [ ] pick up student after school.
- [ ] have report cards or other documents mailed to them. (use for non-custodial parents)

NAME: ____________________
HOME PHONE: ____________________ RELATIONSHIP: ____________________
WORK PHONE: ____________________ CELL PHONE: ____________________
ADDRESS: ____________________

This contact is allowed to: (please check all that apply)

- [ ] be called and pick up student in the event of early dismissal.
- [ ] be called and pick up student if they are sent home due to illness.
- [ ] be called and pick up student due to behavior issues.
- [ ] pick up student after school.
- [ ] have report cards or other documents mailed to them. (use for non-custodial parents)

NAME: ____________________
HOME PHONE: ____________________ RELATIONSHIP: ____________________
WORK PHONE: ____________________ CELL PHONE: ____________________
ADDRESS: ____________________

This contact is allowed to: (please check all that apply)

- [ ] be called and pick up student in the event of early dismissal.
- [ ] be called and pick up student if they are sent home due to illness.
- [ ] be called and pick up student due to behavior issues.
- [ ] pick up student after school.
- [ ] have report cards or other documents mailed to them. (use for non-custodial parents)

Randolph Central Personal Health History 2018-2019

Student's Name: ______________________ Sex: ___M ___F Grade _____ Teacher ______________

Date of Birth: ____________ Primary Address: ______________________________
Student lives with __ Both Parents __ Mother __ Father __ Other: Explain ______________

Mother/Guardian: ______________________ Daytime Phone:______________ Cell: ______________

Father/Guardian: ______________________ Daytime Phone:______________ Cell: ______________

DOCTOR & INSURANCE INFORMATION

Does your child have a doctor? ___Y ___N Insurance Company: ______________ ID # ______________
____ Private ___ Medicaid ___ None

Physician's Name: ______________________ Group/Office ______________________ Phone: ______________

MEDICAL HISTORY

I have been told by a Physician or Healthcare Professional that my child has the following condition/s:
(CHECK ALL THAT APPLY AND LIST ADDITIONAL INFORMATION ON OTHER SIDE)

__ Asthma __ Exercised Induced Asthma __ Inhaler required at school __ Self-carry inhaler (requires Dr.'s order)	__ Heart Disease __ Murmur __ as infant __ currently __ Heart Problem with restrictions (explain on other side)
__ ADD __ ADHD __ On ADD/ADHD Medications __ Autism __ Asperger's Syndrome __ Other: __________	__ Seizures __ From Fever __ Epilepsy __ Shunt __ Unspecified Date of last seizure: ______________
__ Bladder/Kidney concerns (explain on other side) __ Encopresis __ Crohn's disease	__ Frequent Headaches(nonspecific) __ Migraine (requiring medication)
__ Blood/Clotting __ Hemophilia __ Sickle Cell	__ Depression __ Anxiety __ OCD __ Other: ________
__ Deafness __ Hearing aids __ Blindness __ Glasses	**ALLERGIES** (CHECK ALL THAT APPLY)
__ Diabetes type I __ Diabetes type II __ Metabolic Synd.	__ Bee sting __ Wasp sting __ Other insect sting __ Local (swelling at sting site only) __ Epipen/Hospital
__ Diet Restrictions (explain on other side) __ Obesity __ Underweight __ Anorexia __ Bulimia __ Food Intolerance __ Gluten/Celiac __ Lactose Intol.	__ Seasonal (requiring medication) __ Hay Fever __ Animals (List animals on other side) __ Latex (not life-threatening) __ Latex (requires Epi Pen)
__ Head Injury __ Concussion Date: _______	__ Food (life threatening requires Epipen, list on other side)
__ Rheumatoid arthritis __ other musculoskeletal	__ Medication (List medication allergies on other side)
__ Chromosomal/Hereditary disorder (explain on other side)	__ Other Health Condition: ______________

To ensure the care of my child, I read and agree that pertinent health information may be provided to appropriate school staff. This will be done only on a "need to know" basis, in a confidential manner. I agree that the school nurse may consult with my child's family physician(s) about the above medical condition (s). I agree to alert the school nurse and my child's teacher, in writing, of any change in medications and/or health status of my child. In case of emergency involving your child, it is the policy of this school corporation to render first aid treatment while contacting parents for further instructions. If I am unavailable to be reached in order to obtain authorization directly, I do hereby grant the school principal, school nurse, or other appointed designee the authority to act for me and to provide consents and authorization for the delivery of emergency medical care, diagnosis, and treatment, including surgical intervention, if necessary, on behalf of my minor child listed above. The above permission will be valid for one year from the date below, unless I revoke the permission in writing.

__ I believe the above checked condition/s substantially limits one or more of his/her major life activities

Parent/Guardian Signature ______________________________ **Date**______________

Randolph Central Personal Health History 2018-2019

Please give details for all that are marked YES on side one that may impact your child's routine at school.

____
____
____
____
____
____
____

An additional, specific "Individual Health Care Plans" should be in place for students with Asthma, Diabetes, Seizures, Food Allergies, Insect Sting Allergies, and other specific health conditions. Many of these plans require doctor's signatures. Please contact your school nurse as soon as possible to complete the plans.

ADDITIONAL HEALTH INFORMATION

Emergency Information:

My child may require the following emergency medications during school hours:

__ Diastat for seizures __ Epipen for allergic reaction __ Emergency asthma inhaler/nebulizer treatment

(The above listed emergency medications are to be provided by the parent/guardian for the student. The medication must be a current prescription)

__ My child was hospitalized overnight IN THE LAST YEAR: Date: _________ Reason: ___________________________

Medications:

Most medications may be taken at home. Will your child be *required* by a physician to take medication during school hours? __ Yes __ No

All medication taken at school will require an additional signed medication permit on file PRIOR to giving the medication at school. Any changes to the dosage of medications must be made in writing, by the prescribing physician.

List ALL Medications your child takes on a daily basis.

Medication	Amount	Time Taken	Prescribing Physician
1.			
2.			
3.			
4.			
5.			

Secondary Emergency Contacts:

I hereby give Randolph Central Schools permission to contact the following adults in order to pick up/transport my child in the case of emergency. If someone is not on our list and we are unable to contact you for confirmation, your child will NOT be released. Photo I.D.'s will be required before the child is released.

Name: ______________________ Daytime Phone: ______________ Cell phone: ______________

Name: ______________________ Daytime Phone: ______________ Cell phone: ______________

Randolph Central Elementary Schools

Parent/Student Acknowledgement of Student Handbook

We, ______________________________ and ______________________________, have
(Parent/Guardian) (Student)
received and read the Randolph Central Elementary Handbook. We understand the rights and responsibilities pertaining to students and agree to support and abide by the rules, guidelines, procedures, and policies of the School Corporation. We also understand that this handbook supersedes all prior handbooks and other written material on the same subjects.

____
Parent/Guardian Signature

____
Student Signature

____
Date

Randolph Central School Corporation

Permission to Administer Over the Counter Medications

Student's Name:______________________________ Grade: ____________ D.O.B: __________

Medication Allergy: ____

STEP 1: CHECK ALL THAT APPLY

Over-The-Counter medications which are necessary during the school day may be administered during school hours. I hereby authorize the school nurse, principal or other principal designated employee to act on my behalf in administering the following medication(s) on an as needed basis during school hours.

☐ Tylenol ☐ Ibuprofen ☐ Tums ☐ Cough Drops

The nurse's office stocks a limited supply of the above medications. If you child has a history of frequently needing Over-the-Counter medications or requires a medication not listed above, please supply your own medication in the original sealed container. An additional medication release form will need to be filled out, signed, and returned to your child's school before the medication can be administered. All Over-the-Counter medications must be in their original container labeled with your child's first and last name. All medications supplied to the Nurse's Office will be kept in a locked cabinet and used only for your child. The Over-the-Counter medication Aspirin will not be given during the school day without a prescription order from your child's doctor due to the risk of Reye's Syndrome.

All over the counter medications will be administered as directed on the package.

Step 2: TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child, ______________________________, to receive the above medication(s) as directed on the package. I understand and agree that my signature on this form constitutes a waiver of liability. I further acknowledge and agree that when the above medication(s) is administered, I waive any claims I might have against the school district and its employees, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication(s).

______________________________ ______________________ ________________

Parent/Guardian Signature Daytime Phone Date

If you have given your child a dose of any of the above Over-the-Counter medications before school, please make the school nurse/office staff aware so that we are able to follow the proper dosing time frames for the medication

The Migrant Education Program (MEP) provides supplemental education and support services to eligible children through national funding. The purpose of the program is to ensure that all migrant students reach the academic standards and graduate with a high school diploma (or complete GED/HSE).

WORK SURVEY

Thank you for answering the following questions. If your child is eligible for the Migrant Education Program, they may receive additional educational support. This information is **strictly confidential.**

Student's Name: ______________________ Parent's Name: ______________________

Address: ______________________ City: ______________ Telephone: (___) ________

Date: ______________________ Parent Signature: ______________________

1. Within the last **3 years**, have your children moved for any reason? **YES** ____ **NO** _____
2. Has anyone in your household moved from one school district to another within the United States, to look for seasonal or temporary work in agriculture? **YES** ____ **NO** _____

If you answered **NO** to either of these questions, please stop. STOP

If you answered **YES**, please continue.

3. When was the last time you or anyone in your household has moved to look for, or work in an agricultural activity within the United States? Month______________ Year______________
4. Please check any of the agricultural activities listed below that you have looked for or worked in:

_____ Plant or harvest vegetables or fruits
_____ Detassel corn
_____ Tobacco farm
_____ Poultry and/or egg farm
_____ Duck, turkey, chicken, pork or beef processing plant
_____ Aquaculture/fish hatcheries
_____ Canning vegetables or fruits
_____ Sod farm
_____ Planting, pruning or cutting trees
_____ Dairy farm
_____ Flora culture/gladiola farm
_____ Green house or plant nursery

Please list the names of all of the children in the household under 22 years of age.

Child's Name	Date of Birth (D.O.B.)
1.	
2.	
3.	
4.	
5.	

El Programa de Educación Migrante (MEP) provee servicios educativos suplementarios a niños que califican a través de fondos nacionales. El propósito del MEP es asegurar que todos los estudiantes migrantes tengan éxito académico y que se gradúen con su diploma (o que completen el GED/HSE).

ENCUESTA DE TRABAJO

Gracias por contestar las siguientes preguntas. Si su hijo/a es elegible para el Programa de Educación Migrante, podría recibir apoyo educativo adicional. La información es **completamente confidencial.**

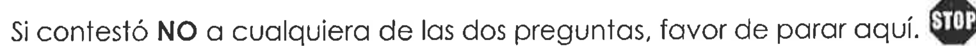
Nombre del Estudiante: ______________________ Nombres de los Padres: ______________________

Dirección: ______________________ Ciudad: ______________ Teléfono: (__) ________

Fecha: ______________________ Firma de los Padres: ______________________

1. ¿Durante los **últimos 3 años**, se ha mudado su(s) hijo(s) por cualquier razón? **SÍ**____ **NO**____
2. ¿Se ha mudado alguien de su familia dentro de los Estados Unidos para buscar trabajo temporal o de temporada en algo relacionado con la agricultura? **SÍ**____ **NO**____

   Si contestó **NO** a cualquiera de las dos preguntas, favor de parar aquí.



Si contestó **SÍ**, favor de continuar.

3. ¿Cuando fue la última vez que usted o un miembro de su familia se mudó para trabajar en la agricultura? Mes ______________ Año ______________
4. Por favor marque en la parte abajo la actividad agrícola en que usted buscó trabajo o trabajó.

____ Matadero de patos, pavos, pollos, cerdos o vacas
____ La espiga (maíz)
____ Cultivar tabaco
____ Pollería o granja de huevos
____ Plantar o cosechar verduras o frutas
____ Trabajar en un criadero de peces
____ Enlatar o congelar verduras o frutas en la bodega
____ Trabajar en la siembra o cosecha de césped
____ Plantar, emparejar o cortar árboles
____ Granja de vacas lecheras
____ Cultivar y cosechar flores
____ Trabajar en la cría de plantas

Por favor escribe los nombres de todos los niños, menores de 22 años de edad, que viven con Usted.

Nombre del niño(a)	Fecha de nacimiento
1.	
2.	
3.	
4.	
5.	

Dr. Jennifer McCormick
Superintendent of Public Instruction

DEPARTMENT OF EDUCATION *Working Together for Student Success*

Confidential

Military Children in Education **2018-19 School Year**

Purpose: This questionnaire is the result of a Department of Defense (DOD) program supported by Indiana statute 20-19-3-9.4. Confidentially identifying military children and providing data on their attendance and educational outcomes, states can assist schools and districts by providing access to data to help inform policy and program decisions for this unique student population. In addition, DOD will benefit from this data in developing policy for military child education initiatives.

School Name: ____ Student's Grade Level: ______________
____

Student's Full Legal Name:
____

Please print clearly

Please complete the questions that best describe your student's situation. It is possible to answer "yes" to both.

1. Is the above named student connected to an Active Duty military family: ______Yes ______No

Meaning a school-aged child, enrolled or in the process of enrolling in KG-12th grade, is claimed as a dependent by an Active Duty member of the Armed Forces of the United States; or the student and an Active Duty member(s) are of the same household whether or not the active duty member(s) claims the student as a dependent.

"Active Duty" means: full-time duty status in the active uniformed service of the United States.

2. Is the above named student connected to a Guard or Reserve military family: ______Yes ______No

Meaning a school-aged child, enrolled or in the process of enrolling in KG-12th grade, who is claimed as a dependent by a member of the National Guard or Reserve; or the student and National Guard or Reserve member(s) are of the same household whether or not the National Guard or Reserve member(s) claims the student as a dependent.

"National Guard or Reserve" means: members of the Reserve Component as defined in 10 U.S.C. Section 10101. Includes Army National Guard of US, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard of US, Air Force Reserve or Coast Guard Reserve.

ONLY for Students of an ADULT High School (IC 20-24-1-2.3)

Is the above named student an active member of the Armed Forces of the United States ______Yes ______No

OR

Is the above named student a member of the National Guard or Reserve ______Yes ______No

Signature: ____Date: ____________________
____

This form shall be handled by schools in a confidential manner in accordance with IDOE Guidance (IC 20-19-3-9.4)