

RUSSELL ELEMENTARY SCHOOL School Year 2009-2010
REGISTRATION + S.A.F.E. FORM (Sports-Activities-Field Trips-Emergencies)

Today's Date _____ Grade Entering _____ Bus Route _____ AM. _____ PM. _____

For office use:
Student I.D. # _____ Date Entering _____ Homeroom _____ Y.O.G. _____

STUDENT INFORMATION: Student's legal name (as it appears on birth certificate)

Legal Last Name _____ Full First _____ Full Middle _____

S.S. # ____ - ____ - ____ Date of Birth _____ Place of Birth _____ M ____ F ____

Home Phone # _____ E-Mail: _____ Language: _____ Race: _____

Legal town of residence: _____ Age Sept. 1: _____

PHYSICAL ADDRESS: (911) _____ **TOWN/ZIP** _____

(Please use actual street name – not RR or RFD)

MAILING ADDRESS: _____ **TOWN/ZIP** _____

(Please use P.O. Box or RR or RFD-actual mailing address)

Previous School and address: _____

PARENT/GUARDIAN INFORMATION:

Primary Contact #1: Parent/Guardian

Last Name: _____ First Name: _____ Relationship: _____

Student Lives with: _____ Home Phone: _____

Employer: _____ Work Phone: _____

E-Mail address: _____ Pager: _____ Cell Phone: _____

Custody: Yes No

Primary Contact #2: Parent/Guardian

Last Name: _____ First Name: _____ Relationship: _____

Employer: _____ Work Phone: _____

E-Mail address: _____ Pager: _____ Cell Phone: _____

Custody: Yes No

Legal Alert:

OTHER important information regarding student's living arrangements and parent/guardian contact information.

EMERGENCY INFORMATION (relative, neighbor, friend)

If parent or guardian is not available, contact: (This information is mandatory- MUST have TWO contacts)

Name _____ Home Phone _____

Address _____ Work Phone _____

Name _____ Home Phone _____

Address _____ Work Phone _____

PLEASE COMPLETE OTHER SIDE

Medical Information and Emergency Authorization:

Doctor's Name _____ Phone: _____
Dentist's Name: _____ Phone: _____

ANNUAL HEALTH SCREENING:

Asthma YES NO
Does your child use an inhaler for respiratory problems? YES NO
Does your child need an inhaler at school? YES NO
Diabetes _____
In the past year, has your child had any head, neck, arm or leg problems? YES NO
If yes, explain: _____
Has your child had any serious illness or operations in the past year? YES NO
If yes, explain: _____
Does your child have any missing paired organ (eye, kidney) or loss of function of an organ? YES NO
If yes, explain: _____
Does your child ever experience chest pain, dizziness, or faintness with exercise? YES NO
If yes, explain: _____
Allergic Reactions: Bee Sting: _____ Need Epi Pen: _____ Penicillin: _____ Medication: _____
Other: _____
Heart Trouble (explain) _____
Blackouts/Seizures (explain) _____
Bleeding Tendencies (explain) _____
Any Other Medical Issues: _____

INSURANCE INFORMATION:

Health Insurance Company: Yes No Healthy Kids: Yes No School Insurance: Yes No
If yes include ID number: # _____ # _____ # _____

EMERGENCY AUTHORIZATION: Please initial each paragraph and sign below!

Treatment & Transportation: I, the parent/guardian, authorize the school's representative to transport and request and authorize treatment for my child in the event of an accidental injury or illness, when a parent/guardian cannot be reached in an emergency situation. I agree that we will not hold this person liable while he/she is acting according to these directions: **Parent/Guardian initial:** _____

Medical Assistance: I, the parent/guardian, authorize the school nurse in writing to assist our child in the taking of medications at school. The medications should be delivered directly to the school nurse's office. The medication must be in the **original** container, with the pharmacy label on it. The label must contain the student's name, the drug's name, the dose, the time the medication is to be given, and the prescribing physician's name. **Students are not allowed to carry medications.** All medications must be left in the nurse's office in the original containers. Inhalers may be kept by the student after a signed permission slip is received from the prescribing physician and the parent/guardian.
Parent/Guardian initial: _____

Field Trip Medication Authorization: I, the parent/guardian, authorize the staff to give my child medications and medical treatments on field trips. The nurse will give the medications and instructions to the staff member prior to the field trip.
Parent/Guardian initial: _____

Contact Doctor/Dentist: I, the parent/guardian, understand that communication between the physician /dentist and the school's health office is necessary for the purposes of sharing information regarding dosage, administration, and effectiveness of medication and I give my authorization for such communication to occur. I also authorize the school nurse to receive copies of necessary paperwork (such as copies of new immunizations, etc.)
Parent/Guardian initial: _____

Over the Counter Medications: I, the parent/guardian, authorize the school nurse to treat minor injuries or illnesses with the following over-the-counter medications. You may **decline** any of the following items by **crossing them out:**
Tylenol...Advil...cough drop...Tums...antibiotic ointment ...anti-itch lotion...hydrocortisone ointment... insect repellent...sunscreen...orajel. **Parent/Guardian initial:** _____

Athletic Health Certification: According to the New Hampshire Interscholastic Athletic Association, students are not eligible for participation in interscholastic sports if they have not successfully passed a physical examination by a doctor every year.

I, the parent/guardian, certify that my child is in good physical condition and able to participate in interscholastic sports and/or any other school sponsored activities during the school year for 2009-2010. **Parent/Guardian Initial:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____