


<p><b><u>OFFICE USE ONLY</u></b></p> <p>Student ID _____</p> <p>Building _____</p> <p>Teacher _____</p> <p>Grade _____</p> <p>Bus # _____</p> <p>Date _____</p>	<p><b>STUDENT REGISTRATION FORM</b></p> <p><b>CASSOPOLIS PUBLIC SCHOOLS</b>  <b>725 Center Street, Cassopolis, MI 49031</b></p>  <p>It is the policy of the Cassopolis Public Schools District that no person shall, on the basis of race, color, religion, national origin or ancestry, age*, sex, marital status*, height**, weight**, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination during any program or activity or in employment. In addition, accommodations will be made to ensure that the lack of English language skills is not a barrier to admission and participation in activities. Inquiries or complaints regarding nondiscrimination policies should be directed to: Bill Yarbrough, Coordinator for Title IX, Title VI, Title II, Section 504 and the Age Discrimination Act, Cassopolis Public Schools, 725 Center Street, Cassopolis, MI 49031; 269-445-0503. *under the education article, age and marital status are prohibited considerations for admissions only **in employment only</p>	<p><b><u>OFFICE USE ONLY</u></b></p> <p>UIC _____</p> <p>School of Choice _____</p> <p>Date Entered _____</p> <p>Date Left _____</p> <p>Updated Info _____</p> <p>Bus Garage _____</p>
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<b>STUDENT INFORMATION</b>			
Name: _____			Gender: Male/Female <i>(please circle)</i>
<i>Last</i>	<i>First</i>	<i>Middle</i>	
Home Address: _____			
<i>Street</i>		<i>Apt. / Lot # / PO Box</i>	
<i>City</i>		<i>State</i>	
<i>Zip</i>			
Birth Date: ____/____/____		Home Phone: _____ <input type="checkbox"/> Listed <input type="checkbox"/> Unlisted	
Has student been previously expelled from school: <input type="checkbox"/> Yes <input type="checkbox"/> No Explain? _____			
Previous student in this district? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, school last attended: _____			

**CONTACT INFORMATION**

**Student resides with:**

_____ both parents	_____ mother/step father	<p><b>According to legal documents DO NOT release my child to:*</b></p> <p>Name: _____</p> <p>Relationship: _____</p> <p>Address if known: _____</p>
_____ mother only	_____ father/step mother	
_____ father only	_____ legal guardian	
_____ foster home	_____ relative (_____)	
_____ court placed	_____ other (_____)	

**\* Provide school office with a copy of any court documents regarding custody / visitation rights**

**Legal Parent(s) / Guardian(s) Living in the Home:**

**Parent/Guardian Name:** \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Last                      First

Address: \_\_\_\_\_ Cell phone: \_\_\_\_\_ ***E-mail:*** \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer phone: \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Last                      First

Address: \_\_\_\_\_ Cell phone: \_\_\_\_\_ ***E-mail:*** \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer phone: \_\_\_\_\_

**Parent Living Elsewhere:** \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Last                      First

Address: \_\_\_\_\_ Cell phone: \_\_\_\_\_ ***E-mail:*** \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer phone: \_\_\_\_\_

**Other Children Residing in the Home:**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

**OTHER EMERGENCY CONTACTS (If Parent / Guardian cannot be reached)**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Daycare Provider: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

*Street City State Zip*

**Race and Ethnicity: (NOTE: Both Parts A and Part B of the question MUST BE answered)**

**PART A**

**Is this student Hispanic / Latino? (Choose only one)**

No, not Hispanic / Latino

Yes, Hispanic / Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

PART A refers to ethnicity, not race. No matter which box you selected above, please continue to answer PART B by marking one or more boxes to indicate what you consider your student's race to be.

**PART B**

**What is the student's race? (Choose one or more; when choosing more than one, enter % for each ethnicity)**

%  **American Indian or Alaska Native** (origins from any of the original peoples of North and South American, including Central America)

%  **Asian** (origins from any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, i.e. Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)

%  **Black or African American** (origins from any of the black racial groups of Africa)

%  **Native Hawaiian or Other Pacific Island** (origins from any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands)

%  **White** (origins from any of the original peoples of Europe, the Middle East or North Africa)

NOTE: **Both Parts A and B MUST BE completed.** We encourage you to select an answer for BOTH parts. If either Part (A or B) is not answered, the U.S. Department of Education **requires** the school district to supply an answer on your behalf.

Student Birth Place: City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

If outside the U.S., when did student enter the U.S.? \_\_\_\_\_ How many years enrolled in U.S. public school? \_\_\_\_\_

Native language: \_\_\_\_\_ Primary language used at home: \_\_\_\_\_

**Please ✓ Health / Medical Information:**

**NO KNOWN MEDICAL PROBLEMS**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ADD/ADHD          | <input type="checkbox"/> Hearing impaired    | <input type="checkbox"/> Bronchitis or breathing problems       |
| <input type="checkbox"/> Asthma*           | <input type="checkbox"/> Seizures*           | <input type="checkbox"/> Eczema or skin conditions              |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Bee sting allergy*  | <input type="checkbox"/> Frequent ear, throat, sinus infections |
| <input type="checkbox"/> Diabetes*         | <input type="checkbox"/> Food allergy*       | <input type="checkbox"/> Heart murmur                           |
| <input type="checkbox"/> Hay fever         | <input type="checkbox"/> Medication allergy* | <input type="checkbox"/> Other heart problems*                  |
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Other allergy*      | <input type="checkbox"/> Other health concerns*                 |

\*Additional Comments: \_\_\_\_\_

Physical Limitations: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician Ph # \_\_\_\_\_

\*If **FIELD TRIPS** are taken during this school year as part of the classroom instruction, do we have your permission for your child to go on fieldtrips that are planned for the class?  Yes  No

\***Cassopolis Schools** designates certain data as directory information which is released for publication in sports programs, honor rolls, and other school programs. **If you object to this information being released, please check here** \_\_\_\_\_

*In compliance with the Federal Status Family Educational Rights and Privacy Act of 1974, Section 99.34 which reads as follows: "Schools may send a student's educational record to officials of other schools or school systems in which the student seeks or intends to enroll, upon condition that the student's parents be notified of the transfer, receive a copy of the record, if desired, and have an opportunity to challenge the content of the record. I affirm that as the parent/legal guardian, all information provided is true and accurate, and that my child and I reside at the above-listed address. I understand any false information provided by me might subject me to legal penalties for perjury."*

*I further authorize Cassopolis Public Schools to share any or all of the aforementioned information with appropriate school staff, for the purpose of providing a safe and healthy environment for my child.*

*In case of accident or serious illness, I request the school to contact me. If this is not possible, I authorize the school to secure emergency medical treatment or make whatever arrangements deemed necessary.*

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

Indicate below any medication that your child takes and dosage/how often it is to be taken:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If medication is to be taken at school please request an authorization form. ABSOLUTELY NO MEDICATION WILL BE DISPENSED AT SCHOOL WITHOUT A DOCTOR'S ORDER ON FILE IN THE OFFICE.**

**SPECIAL NEEDS INFORMATION**

Special Program Received at Prior School:  
 Special Ed  Plan 504  Speech & Language  Title 1 Services  
 Other \_\_\_\_\_

**OFFICE USE ONLY**

<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Request for Records
<input type="checkbox"/> Immunizations	<input type="checkbox"/> Temporary Placement
<input type="checkbox"/> Proof of Residency	<input type="checkbox"/> Legal Documents

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