

MACOMB ACADEMY OF ARTS AND SCIENCES
STUDENT REGISTRATION / EMERGENCY FORM (2008-2009)

Student Information (Please print)

Grade: _____ Home Phone: _____

Last Name: _____ First Name: _____ Middle Initial: _____ Sex: _____

Address: _____ PO Box #: _____ City: _____ Zip: _____ County: _____

Birthdate: _____ City & State of Birth: _____ Social Security #: _____

Former School _____ District _____ City _____ State _____

Parent/ Guardian Information

Mother/Guardian – Name

Father/Guardian – Name

Step Parent/Guardian – Name

Home Address – (If different than student)

Home Address – (If different than student)

Home Address – (If different than student)

Marital Status Pager:

Marital Status Pager:

Marital Status Pager:

Home Phone: Cell Phone:

Home Phone: Cell Phone:

Home Phone: Cell Phone:

Employer Name: Phone:

Employer Name: Phone:

Employer Name: Phone:

Resides with student: Yes No

Resides with student: Yes No

Resides with student: Yes No

E-mail Address

E-mail Address

E-mail Address

Other Children in Armada Schools

Name: (Last Name/First Name)

Birthdate:

Grade/Teacher:

1. _____
2. _____
3. _____

Emergency Contact Information (other than parent)

Name:

Phone Number:

Relationship to student:

1. _____
2. _____
3. _____

Student Contingency Plan

My child has been instructed where to go if there is an unscheduled dismissal (i.e. tornado, snow storm).

Yes _____ No _____

My Child May Not Leave With: _____

PLEASE TURN THE FORM OVER AND COMPLETE PAGE TWO™

Student Health Information

Please check if your child has:

Asthma _____ Orthopedic Handicap _____ Physical Handicap _____ Insect Bite Reaction _____ Diabetes _____
Epilepsy _____ Vision Problems _____ Hearing Problems _____ Heart Condition _____ Kidney Disease _____
Allergies _____ Other _____

***No medications can be administered without an accompanying medication authorization form. Forms are available in the School Office.**

In case of accident or serious illness, I request the school to contact me. If the school is unable to contact me, I hereby authorize the school to contact the physician, the school may make whatever arrangements that seem necessary. I agree to assume financial responsibility for these emergency referrals (this includes hospital, medical and ambulance services).

Physician: _____ Phone: _____

Hospital Preference: _____ Health Insurance: _____

Policy Number: _____ Orthodontist: _____ Phone: _____

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Parent or Guardian

Date

TO BE COMPLETED BY PARENT/GUARDIAN IF THIS IS A NEW ENROLLMENT:

WAS YOUR CHILD RECEIVING SPECIAL HELP? (CHECK ALL THAT APPLY):

Title I Speech & Language Special Education Other _____

Language spoken in Home _____

PLEASE CIRCLE ONE:

- | | | |
|-------------------------------------|--------------------|--------------------------------------|
| 1. American Indian | 3. Black | 5. White |
| 2. Asian or Pacific Islander | 4. Hispanic | 6. Multiracial – Please list: |

FOR OFFICE USE ONLY:

Sasi Sirs

SENT FOR RECORDS (DATE) _____

STUDENT NUMBER _____

RECEIVED:

IMMUNIZATION

PROOF OF RESIDENCY

HEARING/VISION

BIRTH CERTIFICATE

SOCIAL SECURITY #

(For Kindergarten & Readiness)

START DATE _____ WITHDRAWAL DATE _____

SCHOOL NAME

DISTRICT

CITY / STATE

ZIP