

Social Circle City Schools Registration-- Student and Household Information

Complete a separate card for each student.

Today's Date: _____ NAME STUDENT CALLED: _____ SCHOOL REGISTERING: SCPS SCES SCMS SCHS

Student's Full, Legal Name:	Gender:	Birth Date:	Social Security Number: ¹				
Hispanic ² Yes No Birth Country, if not USA: _____ Date entered USA: _____ Date entered USA School: _____	Race ² (Circle <i>all</i> that apply) -American Indian -Asian -Black or African American -Native Hawaiian or Other Pacific Islander -White		Grade: If High School Student, provide Date Entered 9 th Grade:				
	Migrant: Yes No	Homeless: Yes No If Yes, what is the Primary Night Shelter:	Gifted: Yes No				
	ELL: Yes No If Yes, Primary Home Language: _____		Free or Reduced Lunch: Yes No	Did Student Attend Pre-K Yes No			
Early Intervention Program: Yes No	Special Education: Yes No		If Yes, where: _____				
Transportation: Bus Rider Car Rider Walker		Previous School Attended: _____					
Enter Relationship to each individual (by number) in the Household Table.							
1.	2.	3.	4.	5.	6.	7.	8.

1: SSN is not required. Currently, the Georgia Student Finance Commission (Hope Scholarship) does not accept transcripts without a valid social security number. If student has attended another Georgia school, please provide the Georgia 800 number.

2: Federal Requirement – If you choose not to supply the information, Federal Law requires that the school determine race by observation.

Signature of Person Completing Form

Signature of School Verification Official

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HEALTH INFORMATION

STUDENT'S LAST NAME: _____

PLEASE SEND WRITTEN NOTICE TO CHANGE AND UPDATE THIS INFORMATION, IF IT CHANGES DURING THE SCHOOL YEAR.

Does the student have a history of:	If yes, give type and date of last occurrence:	If current, what treatment/medicine is student receiving:	Name of Medical Insuror:
ALLERGIES: YES NO			
ASTHMA: YES NO			Insurance I. D. #
CANCER: YES NO			
SEIZURE DISORDER: YES NO			Group I. D. #
SICKLE CELL: YES NO			
PHYSICAL DISABILITY: YES NO			Primary Care Doctor:
CARDIAC DISEASE: YES NO			
			Doctor's Office #:
DIABETES: YES NO			
If YES, is special diet required?			
YES NO			
Is student insulin dependent?			
YES NO			
SCHOOL USE ONLY			
HEARING DIFFICULTIES:		Uses a hearing aid: YES NO	Ga. Imm. 3231
YES NO			
VISION DIFFICULTIES:		Wears glasses: YES NO	Ga. EED 3300
YES NO			
Other: YES NO			Ga. Imm. 3231
Specify: _____			(6 th -Booster)
Other: YES NO			
Specify: _____			

IF MEDICATION IS TO BE TAKEN AT SCHOOL, PLEASE CONTACT THE SCHOOL NURSE FOR PROPER PERMISSION FORM.

School Clinic personnel have my permission to contact my child's physician for further medical information. If case of a serious illness/injury, the school will telephone Emergency Medical Services (911) for immediate transportation to the closest hospital.

I, the parent/guardian, authorize the transport of and treatment by the hospital emergency staff for my child, (name)_____.

PARENT SIGNATURE

DATE

Signature, School Verification Official