



For School Use Only

School Year: _____ School: _____ Grade: _____ Student ID: _____

Registration Date: _____ Start Date: _____

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|---|--|---|
| <input type="checkbox"/> New Enrollment | <input type="checkbox"/> Returning Student | <input type="checkbox"/> Open Enrollment |
| <input type="checkbox"/> Tuition Student | <input type="checkbox"/> Tuition Waived | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Proof of Residency | <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Immunization Records |

Student Enrollment & Registration Information

STUDENT INFORMATION

Student Last Name: (as appears on birth certificate)		First Name:	Middle Name:	*Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth City:	Birth County:	Birth State:
Has student previously attended Ripon Area School District? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, by what name:	
School Last Attended:	City, State, Zip:	Phone:	*Current Grade:	
Has student been expelled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is student under consideration for expulsion? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the student Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the student from one or more of these races? <i>(check all that apply)</i> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander		

PRIMARY RESIDENCE INFORMATION

When the parent/guardian's of a student do not share the same address, the address listed below will be used as the student's permanent resident address for registration purposes. This address shall be known as the primary address.

Primary Street Address:		City, State Zip:		
Parent/Guardian Legal Name:		Relationship to Student: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Step-parent <input type="checkbox"/> Other: _____		
Date of Birth:	Cell Phone:	Employer:	Work Phone:	
Email Address:		Does this adult have rights to the student's records? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Parent/Guardian Legal Name:		Relationship to Student: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Step-parent <input type="checkbox"/> Other: _____		
Date of Birth:	Cell Phone:	Employer:	Work Phone:	
Email Address:		Does this adult have rights to the student's records? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECONDARY RESIDENCE INFORMATION

When the parent/guardian's of a student do not share the same address, the address listed below will be used as the student's secondary resident address for registration purposes. This address shall be known as the secondary address.

Secondary Street Address:		City, State Zip:	
Parent/Guardian Legal Name:		Relationship to Student: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Step-parent <input type="checkbox"/> Other: _____	
Date of Birth:	Cell Phone:	Employer:	Work Phone:
Email Address:		Does this adult have rights to the student's records? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent/Guardian Legal Name:		Relationship to Student: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Step-parent <input type="checkbox"/> Other: _____	
Date of Birth:	Cell Phone:	Employer:	Work Phone:
Email Address:		Does this adult have rights to the student's records? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the secondary parent... <i>(Please check the applicable boxes)</i> <input type="checkbox"/> Share custodial and/or guardianship of student <input type="checkbox"/> Receive mailings from school <input type="checkbox"/> Have rights to view the Parent Portal <input type="checkbox"/> Have visitation rights <input type="checkbox"/> Have joint-custodial rights <input type="checkbox"/> Have curtailment of rights & privileges		Is there any legal information pertaining to the student that the school district should be aware of? <i>Please submit a copy of legal documents.</i>	

CENSUS DATA

Please list all unmarried children, ages birth through twenty (20) years, who live in the primary household.

Child's Name (first, middle, last)	Male/Female	Date of Birth

MEDICAL/EDUCATIONAL NEEDS

Please check any of the following services the student received in a previous school:

<input type="checkbox"/> Speech/Language Therapy <input type="checkbox"/> Learning Disabilities Services <input type="checkbox"/> Intellectual Disabilities Services <input type="checkbox"/> Emotional Disturbance Services <input type="checkbox"/> Gifted/Talented Program <input type="checkbox"/> Vision Services <input type="checkbox"/> Social Work Services <input type="checkbox"/> Section 504 Accommodations <input type="checkbox"/> Autism Services	<input type="checkbox"/> Traumatic Brain Injury Services <input type="checkbox"/> Nursing Services <input type="checkbox"/> Hearing Services <input type="checkbox"/> Physically Disabled Services <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> School Counseling <input type="checkbox"/> Title I	<input type="checkbox"/> Other <i>(please explain below)</i> :
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Please sign and date that you have reviewed the medical/educational needs data.

_____ (signature)

_____ (date)

Health & Emergency Consent Form New Student Registration

Student Name:	Date of Birth:	Grade:
Student Lives With: <i>(choose one)</i> <input type="checkbox"/> both parents, same household <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> 50/50 placement <input type="checkbox"/> Other: _____	Primary Address:	
	Secondary Address: <i>(if applicable)</i>	
Medical Conditions/Physical Disabilities:	Medications Taken on a Regular Basis:	
Other Environmental/Food Allergies:	Medication Allergies:	
Physician Name:	Physician Phone:	
Dentist Name:	Dentist Phone:	

I have completed and reviewed the above information and verify that it is accurate. In an emergency, I authorize the nurse, principal, or designated school personnel to call the physician or dentist identified. If necessary, I authorize the nurse, principal or designated school personnel to call an ambulance and the doctor on-call at the nearest medical facility. I do hereby authorize (check as appropriate):

Physician Treatment

Dental Treatment

(Parent/Guardian Signature)

(Date)

(Please complete emergency contact information on reverse side)



EMERGENCY CONTACT INFORMATION

In case of an injury or illness with your child, the school will contact the people on the following list, in the order listed.

Contact #1

Name:		Relationship:	
Home Phone:	Cell Phone:	Work Phone:	Email:
Place of Work: (include any special instructions for reaching you at work):			

Contact #2

Name:		Relationship:	
Home Phone:	Cell Phone:	Work Phone:	Email:
Place of Work: (include any special instructions for reaching you at work):			

Contact #3

Name:		Relationship:	
Home Phone:	Cell Phone:	Work Phone:	Email:
Place of Work: (include any special instructions for reaching you at work):			

Contact #4

Name:		Relationship:	
Home Phone:	Cell Phone:	Work Phone:	Email:
Place of Work: (include any special instructions for reaching you at work):			