

REGISTRATION FORM
FREDERICK AREA SCHOOL DISTRICT

Name: _____ Grade _____ Sex: M ___ F ___

Name to be used in school if other than above (nickname): _____

Birth Date: _____ Place of Birth: _____
Month / Day / Year City / State

Are you of Hispanic Origin? _____ Yes _____ No
Ethnic Background: _____ Asian Black (not Hispanic)
Hispanic White (not Hispanic)
American Indian or Alaskan Native
Native Hawaiian or Pacific Islander

Does your child speak any language other than English? _____ Yes _____ No

If yes, please answer the following questions:

1. What was the first language your child learned to speak? _____
2. What language does your child speak most often? _____
3. What language is most often spoken in your home? _____

Social Security Number: _____

School last attended: _____
(Name of school) (Address of School)

Date Enrolled in Frederick Area School: _____

Marital Status of Parents: Married _____ Divorced _____ Separated _____

Child lives with: Both parents _____ Mother _____ Father _____ Other _____

Father's Name: _____ Father's Occupation: _____

Father's Home Phone Number: _____ Father's Business Phone: _____
Father's Cell Phone: _____

Father's Address: _____
(Street) (City) (State)

You are the legal guardian of your children: Yes _____ No _____

Mother's Name: _____ Mother's Occupation: _____
(Maiden)

Mother's Home Phone Number: _____ Mother's Business Phone: _____
Mother's Cell Phone: _____

Mother's Address: _____
(Street) (City) (State)

You are the legal guardian of your children: Yes _____ No _____

If there are individuals who are not allowed access to your child/children, please list the names below: *

Court documents are required to be on file at the school.

Step Parent or Guardian's Name: _____

Occupation: _____ Phone Number: _____
Cell Phone Number: _____

Who cares for the child/children if the parent/guardian works outside the home? _____

Caretaker's Phone Number: _____ Cell Phone Number: _____

Has your child attended pre-school? Yes ___ No ___ Location: _____

Please list the names of your children living with you starting with the oldest:

Name	Birth Date	Sex	At Home	In School	Other Location

Does anyone other than your husband (or wife) and child/children live with you? Yes ___ No ___

If yes: (Name) _____ (Relationship to child/children) _____

Has there been any indication of difficulties in the following: (Check those that apply)

Learning ___ Hearing ___ Speech ___ Sight ___ Other Physical ___

If so, please comment: _____

Has your child/children received special education or Title services? Yes ___ No ___

If so, please comment: _____

Have there been any circumstances in your child's life that you believe have affected your child and that you think would help us understand the child? Please explain:

Hand Preference: Right ___ Left ___ Both ___

In case of emergency and if parents/guardians cannot be reached the school should contact:

Name: _____ Address: _____ Phone: _____

Family Physician: _____
(Name) (Address) (Phone)