

Caddie Woodlawn Early Learning Center - Grade – _____
Annual Registration - Medical Update – 2017-18

Name: _____ Gender: _____
Date of Birth: _____ (Office Use: Homeroom _____)
Miles from Home to Caddie: _____ Social Security #: _____ - _____ - _____ County of Residence: _____
Address: _____ City, Zip _____
Phone #: _____ Cell #: Mom: _____ Dad: _____
e-mail address: Mom: _____ Dad: _____
Resides With: _____ (e.g. Mr. and Mrs.; Ms.; Mr. etc.)
____ Mother & Father ____ Father only ____ Mother only ____ Father & Stepmother ____ Mother & Stepfather
____ Foster Parents ____ Guardian _____ Other

Please answer BOTH questions:

1. Is this student Hispanic or Latino: ____ YES or ____ NO
2. Choose one or more. You **MUST** select at least one:
____ American Indian or Alaskan Native ____ Black or African American ____ White
____ Native Hawaiian or Other Pacific Islander ____ Asian

Father's Name: _____ Address: _____

Father's Home Phone: _____ Employer: _____ Work Phone: _____

Mother's Name: _____ Address: _____

Mother's Home Phone: _____ Employer: _____ Work Phone: _____

Student's Last School: _____ Address: _____

Family Doctor: _____ City: _____ Phone #: _____

Alternate person to contact in case of illness/emergency:

1. _____ Phone # _____ Cell # _____

2. _____ Phone # _____ Cell # _____

List health conditions that require emergency action or special treatment at school. (e.g. asthma, diabetes, severe allergic reaction, seizure disorder, severe allergies, visual or hearing impairment) Health information is shared with staff on a need to know basis. (Contact school nurse if specific Health Care plan is needed.)

Please list medications taken routinely: _____
(If taken at school, contact the school office or school nurse for medication forms.)

List any immunizations received since last year. Type and date given. _____

Please check if student is currently in any specialized programming (e.g. Special Ed., 504, Title 1, Gifted & Talented):
____ YES ____ NO If 'yes' please specify: _____

I give the Caddie Woodlawn Early Childhood Center – School District of Durand the authority to secure professional medical services when parent or alternate person cannot be reached or when injury is of such a severe nature that immediate attention is necessary.

(Signature of Parent or Guardian)

(Date)

Child's Birth Information - City: _____ County: _____ State: _____

Country if not USA: _____