MIDLAND MIDDLE SCHOOL REGISTRATION INFORMATION
2007-2008

Student's Name: ________________________ **Grade:** ________ **D.O.B.:** ________________

Sex: ○ Male ○ Female **Race:** ○ White ○ Black ○ Asian ○ Hispanic ○ American Indian ○ Multi-Racial

Student's Address: ____ **Zip:** ______________

Name of person with whom student lives: ______________________________ **Home Phone:** ____________

Relationship to student: ○ Parent ○ Legal Guardian ○ Foster Parent ○ Relative ○ Friend ○ Other ________________

Name of school last attended: ____

Address of last school attended: ____ **Zip:** ______________

Has student ever attended a Columbus Public School? ○ Yes ○ No **If yes, please give last year of attendance:** ________

Name of Columbus public school of last attendance: ____

Has student ever been assigned to a special education class? ○ Yes ○ No What kind? ______________________

What was the language(s) the student first learned to speak? ○ English ○ Spanish ○ Other: ________________

What language(s) does the student speak at home? ○ English ○ Spanish ○ Other: ______________________

What language(s) does the student speak most often? ○ English ○ Spanish ○ Other: ______________________

Father / Legal Guardian: ______________________________ **Occupation:** ______________________

Employer: ____ **Work Phone:** ______________________

Mother / Legal Guardian: ______________________________ **Occupation:** ______________________

Employer: ____ **Work Phone**: ______________________

Emergency Phone No.: __________________ **Person to reach at this number:** ______________________

Is either parent active duty military? ○ Yes ○ No **Is either parent a civilian employed at Fort Benning?** ○ Yes ○ No

PERSON, OTHER THAN PARENT, AUTHORIZED TO PICK UP STUDENT:

Name: ______________________________ Phone: ________________ Relationship: ______________

Name: ______________________________ Phone: ________________ Relationship: ______________

PERSON(S) WHO CANNOT PICK UP STUDENT:

Name: ______________________________ Phone: ________________ Relationship: ______________

Name: ______________________________ Phone: ________________ Relationship: ______________

SPECIAL HEALTH PROBLEMS (Check all which apply):

○ Asthma	○ Epilepsy (Seizures)	○ Insect Sting Allergy	○ Environmental Allergy
○ Diabetes	○ Food Allergy	○ Kidney Problem	○ Physical Handicap
○ Drug Allergy	○ Heart Condition	○ Milk Allergy	○ Other ______________________

Does student wear glasses? ○ Yes ○ No **Contact lenses?** ○ Yes ○ No **Hearing aid?** ○ Yes ○ No

Does student require medication routinely? ○ Yes ○ No **What kind?** ______________________________

Reason or health problem for which medication is required: ______________________________________

Name of family doctor: ________________________ **Doctor's telephone number:** __________________

Is student a military dependent served by Martin Army Hospital? ○ Yes ○ No

Is there a medical reason which prohibits this student's participation in physical education? ○ Yes ○ No

(IF YES, PLEASE SUPPLY A DOCTOR'S STATEMENT FOR SCHOOL FILES)

BROTHERS & SISTERS 18 YEARS OF AGE OR UNDER:

Name: ______________________________ Birthday: ________________ School: __________________

Name: ______________________________ Birthday: ________________ School: __________________

In the event of an emergency, may a representative of the school contact the family doctor if the Parent/Legal Guardian cannot be reached? ○ Yes ○ No **Also, the school has permission to call an ambulance to transport my child to the hospital in an emergency if the Parent/Legal Guardian cannot be reached?** ○ Yes ○ No

Date: ______________________ **Signature of Parent/Legal Guardian** ______________________________