Martins Ferry City School District

STUDENT REGISTRATION FORM **School Year: 2020-2021** #1

Today's Date_____ Grade: Kg. Email_____

Student's Name_____
Last First Middle

_____ _____
Street Address First Call Phone Number

_____ _____
Mailing Address Home Phone Number

_____ _____
City State Zip Student's **Date of Birth**

_____ _____ _____
Gender (M or F) Student's **Native Language** Student's **City of Birth**

_____ US Citizenship _____Yes _____ No
Mother's Maiden Name (as it appears on student's birth certificate)

Is this student Hispanic/Latino? _____ Yes _____ No
(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Is student part of a military family? _____Yes _____No

Which of the following five racial groups applies to the student? Check all that apply.

_____ **American Indian or Alaska Native** - person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.

_____ **Asian** - persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indiana subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

_____ **Black or African American** - persons having origins in any of the black racial groups in Africa.

_____ **Native Hawaiian or Other Pacific Islander**

_____ **White** - people who have origins in any of the original peoples of Europe, North Africa, or the Middle East.

_____ _____ _____
Mother's Name Place of Employment Work or Contact Number

_____ _____ _____
Father's Name Place of Employment Work or Contact Number

Parents are: ___ Married ___ Separated ___Divorced ___Father Deceased ___Mother Deceased ___Never Married

Note: If the student does not reside with parents, legal documentation must be provided to the school at time of enrollment.
Ex: Official court papers, legal guardianship papers, etc.

Student previously enrolled in Martins Ferry City School? ___Yes ___No Resident of Martins Ferry School District? ___Yes ___ No

If not enrolling as a resident - list name of home school district_____

Previous School:_____
Name City/State Phone/Fax Number

List any medical conditions_____

_____ _____
Parent/Guardian Signature and Relationship to Student Date

OFFICE USE ONLY

Student ID#_____ _____ Teacher

#2

OHIO SCHOOL HEALTH HISTORY

To be completed by parent or guardian

School_____

Enrolled_____

Withdrawn_____

Child's full name_____
Last First Middle

Male_____Female_____ Birthdate_____
Month Day Year

Child's address_____

Father's name_____

his address (if different from child's)_____

his work phone_____ his home phone_____

Mother's name_____

her address (if different from child's)_____

her work phone_____ her home phone_____

With whom does child live?_____
Name Relationship

Who is this child's legal guardian?_____

Please list this child's brothers and sisters:

FAMILY HISTORY

	birth year	sex		birth year	sex
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

PERINATAL HISTORY

Did the mother have any unusual physical or emotional illness during this pregnancy? yes_____ no_____

If yes, explain briefly_____

How old was the mother when this child was born?_____

Was this infant born: full term_____ early_____ late_____ What was the infant's birth weight?_____

Did the infant have any sickness or problems while in the nursery? yes_____ no_____

If yes, explain briefly_____

DEVELOPMENTAL HISTORY

Please give the approximate age at which this child:

walked alone_____ was toilet trained_____ spoke in sentences_____ dressed self_____

How does this child's development compare to other children, such as his or her brothers/sisters or playmates?

about the same slower faster

#3

CHILD HEATH HISTORY, CONTINUED:

I. HEALTH CONDITIONS - Please check any that this child has had:

___ Abnormal spinal curvature (scoliosis, etc.)
___ Allergies or hayfever
___ Anemia
___ Arthritis
___ Asthma or wheezing
___ Bedwetting at night
___ Behavior problem
___ Birth or congenital malformation
___ Cancer, type_____
___ Chicken pox
___ Chronic diarrhea or constipation
___ Concern about relationship with siblings or friends
___ Cystic fibrosis
___ Diabetes
___ Eczema
___ Emotional problems
___ Eye problems, poor vision
___ Frequent headaches
___ Frequent skin infections
___ Frequent sore throat infections
___ Heart disease, type_____
___ Hepatitis
___ Kidney disease, type_____
___ Measles ("old fashioned" or "ten day")
___ Meningitis or encephalitis
___ Multiple ear infections (3 or more)
___ Mumps
___ Near-drowning or near-suffocation
___ Nervous twitches or tics
___ Poisoning
___ Poor hearing
___ Pregnancy
___ Rheumatic fever
___ Seizures or epilepsy
___ Sickle cell disease
___ Stool soiling
___ Substance abuse (alcohol, drugs)
___ Suicide attempt
___ Toothaches or dental infections
___ Urinary tract infection
___ Wetting during day

II. ALLERGIES - Please list and describe allergies or reactions to:

Medicines/drugs_____
Foods/Plants/Animals/Other_____
Recommended treatment if allergy is severe_____

III. INJURIES AND ILLNESSES - Please list any severe injuries or illnesses:

Injuries/Illnesses	Age of Child	If Hospitalized (check)

Does this child **always** wear seatbelts in cars? Yes_____ No_____

IV. ADDITIONAL INFORMATION:

What medications are given daily?_____
What medications are given frequently, but not daily?_____
This child is usually: very active_____ normally active_____ rather inactive_____
Do you have any concern about how your child gets along with other children?

_____
_____

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly_____

_____
_____
_____
_____

Completed by:_____
Relationship to child_____

#4

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

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Health History continued

#5

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /

#6

MARTINS FERRY PUBLIC SCHOOLS

INFORMATION CARD FROM PARENT TO TEACHER

Child's Name in Full_____
FIRST NAME MIDDLE NAME LAST NAME

Date of Birth_____ Telephone No._____

Residence, Street_____ No._____

Place of Birth_____

Occupation of Parent or Guardian_____

Resident of City School District? Yes/No_____ Child's health good or poor?_____

If there are any physical defects of which the teacher should be informed such as defective sight, hearing, nervousness or kidney trouble, please report such to teacher on this card.

_____

_____

Date_____ _____ Parent or Guardian

Names