

## East Baton Rouge Parish School System Student Registration and Data Verification Form

**SCHOOL OFFICE COPY: SCHOOLYEAR**

**SCHOOL USE ONLY:**

Student ID Number	Grade	Entry Date	Teacher Name
Teacher #	School Number	School Use	

**Parents: This is your child's registration form. Please complete all blank items in each section on ALL PAGES.**

***STUDENT INFORMATION***

Student's LEGAL Last Name                      First Name  
 Student's Address                      Apt.  
 Zip Code                      Birth Certificate Number

<input type="checkbox"/> Male	<input type="checkbox"/> Am. Ind./Alaskan Native	Has the student ever attended a school in Louisiana? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Female	<input type="checkbox"/> Asian/Pacific Islander	Has the student ever attended a school in EBRPSS? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Black (not of Hispanic Origin)	Last school attended?                      if school is not in EBRPSS
	<input type="checkbox"/> Hispanic	Street                      City                      State                      Zip
	<input type="checkbox"/> White (Not of Hispanic Origin)	Is this student the subject of a court or custody order? ? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Other	If yes, please provide a copy of the order to the school.
		Language spoken at home                      Language first acquired by student
		Language most often spoken by student

Has this student ever received services as an Exceptional Student?  Yes  No  
 If yes, Please indicate the student's exceptionality:  Gifted  Talented  Other

Brothers/Sisters in an EBR School this year	Date of Birth (Mo/Day/Yr.)	School	Grade

***PARENT/GUARDIAN***

Relation                      Does the student reside at this address?  Yes  No  
 Last Name                      First Name                      Home Phone  
 Address                      Apt. #                      Zip                      Cell Phone                      Other Phone  
 Place of Employment                      Work Phone

Relation                      Does the student reside at this address?  Yes  No  
 Last Name                      First Name                      Home Phone  
 Address                      Apt. #                      Zip                      Cell Phone                      Other Phone  
 Place of Employment                      Work Phone

Person with whom the student lives if not the parent/guardian:  
 Last Name                      First Name                      Home Phone  
 Address                      Apt. #                      Zip                      Cell Phone                      Other Phone  
 Place of Employment                      Work Phone

***GENERAL STUDENT INFORMATION***

Person Authorized to Pick up Your Child                      Home Phone                      Other Phone  
 Person Authorized to Pick up Your Child                      Home Phone                      Other Phone  
 Emergency Contact                      Home Phone                      Other Phone  
 Emergency Contact                      Home Phone                      Other Phone  
 After school, how does the student get home or to after school care:  
 Student's Doctor/Clinic                      Doctor's Phone                      Clinic's Phone  
 Hospital of Choice  
 Special medical conditions/allergies/procedures of which the school should be aware

**ALL OF THE ABOVE INFORMATION IS CORRECT PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**HEALTH SERVICE OFFICE COPY: SCHOOL YEAR**

Student's LEGAL Last Name                      First Name                      Middle Name                      DOB  
Student's Address                      Apt.                      Zip Code                      SSN

**Contact Person**                      Relationship                      Does the student reside at this address?  Yes  No  
Last Name                      First Name                      Home Phone                      Work Phone  
Address                      Apt. #                      Zip                      Cell Phone                      Other Phone

**Contact Person**                      Relationship                      Does the student reside at this address?  Yes  No  
Last Name                      First Name                      Home Phone                      Work Phone  
Address                      Apt. #                      Zip                      Cell Phone                      Other Phone

Other Emergency Contact                      Home Phone                      Work Phone  
Student's Doctor/Clinic                      Doctor's Phone                      Clinic's Phone

Special medical conditions/allergies/procedures of which the school should be aware

Medicines taken regularly at Home

Medicines taken regularly at School

Does the student have (check one) Private Insurance  Yes  No    Medicaid  Yes  No    LACHIP  Yes  No  
Parent/guardian request insurance information  Yes  No

**ALL OF THE ABOVE INFORMATION IS CORRECT PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**ELECTRONIC COMMUNICATION SYSTEM:** I hereby understand that students of the East Baton Rouge Parish School System will be granted access to the system's electronic communications system which includes access to the Internet and Worldwide Web. This access is a privilege, not a right. The system may suspend or revoke a system user's access upon violation of system policy and/or administrative regulations regarding acceptable use or upon written parental request to the campus principal.

I have read the East Baton Rouge Parish School System electronic communications system policy and administrative regulation. These are provided at the time of registration as well as being available at each school. The information also may be found on the East Baton Rouge Parish School System website <http://www.ebrschools.org>.

I further understand that the East Baton Rouge Parish School System will not publish my child's individual photograph, video, and/or last name without my written permission.

**PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**PARENT E-MAIL ADDRESS (OPTIONAL):** The system would like to communicate with you via e-mail should you wish. Provision of an e-mail address is not required. If you do not provide an address, the system will continue to communicate with you in its regular manner to assure continued provision of vital and important information.

My e-mail address is

**PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**DIRECTORY INFORMATION:** The East Baton Rouge Parish School System regularly receives requests for directory information on students enrolled in the System. Director information includes, but is not limited to, information such as student name, address, telephone number, date and place of birth, photographs, participation in sports, grade level, dates of attendance, enrollment status and e-mail address.

I GIVE     I DON'T GIVE permission to release student directory information.

**PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**STUDENT HEALTH SERVICES:** I understand that Health Care Centers in Schools/EBRPSS School Health Team ("Health Team") will provide school health services in cooperation with EBRPSS staff as outlined in the attached summary, and give permission for the Health Team, or any EBRPSS employee or any other staff under the guidance of the Health Team, to provide the described services to the student as he/she may require while present in school. I understand that, if the student has a serious injury or illness, I will be contacted and the physician/clinic shown on the reverse side of this form and/or Emergency Medical Services (EMS) may be contacted if necessary. I understand and agree that neither Health Care Centers in Schools nor EBRPSS nor their staff will be responsible for any cost involved if the student needs emergency medical care. I understand and agree that in order to provide a coordinated system of care, the Health Team may exchange health care information about the student with the student's physician or other health care providers, upon approval by me. I understand and agree that the Health Team may share the student's health care information with EBRPSS personnel, in accordance with protocol, in order to provide appropriate attention to the Student's health needs.

**PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**