



Student Registration form

First Name	
Middle Name	
Last Name	
GENDER M or F	
Date of Birth <small>(Month/Day/Year)</small>	/ /
Grade Level	

Method of contact

Guardian's Name	
Relationship to student	
Address
E-mail	
Home Phone#	
Cell phone#	
Work phone (if applicable)	
If we need to contact you, which phone to dial first?1,2,3	<input type="checkbox"/> Home <input type="checkbox"/> cell phone <input type="checkbox"/> Work phone

Medical status

Does the student suffer from any of the following impairments? <small>(tick)</small>	Hearing: <input type="checkbox"/> Yes <input type="checkbox"/> No Speech: <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No Mobility: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child suffer from any medical condition or allergies which school staff needs to be aware of Y or N? <p style="text-align: center;">If YES, Details →</p>	Details <hr/> <hr/> <hr/> <hr/> <hr/>		

Guardian signature:

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Date:

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