

LUCERNE ELEMENTARY SCHOOL DISTRICT
 3351 Country Club Drive, P.O. Box 1083, Lucerne, CA 95458
 (707) 274-5578 ~ www.lucerne.k12.ca.us

OFFICE USE ONLY

Teacher_____	Grade_____
ID#_____	SSID #_____
Cum Req'd _____	Cum Rec'd _____

REGISTRATION FORM

DATE_____

STUDENT'S LEGAL NAME _____ / _____ / _____

Last First Middle SSN#

GENDER_____ AGE_____ GRADE_____ DATE OF BIRTH_____ BIRTHPLACE_____

CURRENT STREET ADDRESS_____

MAILING ADDRESS_____

LAST SCHOOL ATTENDED_____ PHONE_____

HAS STUDENT EVER BEEN EXPELLED? **YES / NO** HAS STUDENT EVER REPEATED A GRADE(S)? **YES / NO** (IF YES, WHICH GRADE?) _____

CHILD IS LIVING WITH: () BOTH PARENTS () FATHER () STEPFATHER () MOTHER () STEPMOTHER () GUARDIAN () FOSTER

IS THERE A CURRENT RESTRAINING OR COURT ORDER THAT AFFECTS THIS STUDENT? **YES / NO**
 (IF YES, PLEASE GIVE THE SCHOOL OFFICE A COPY OF LEGAL DOCUMENTS AFFECTING THIS STUDENT)

CIRCLE ONE →	FATHER / STEPFATHER / GUARDIAN / FOSTER	MOTHER / STEPMOTHER / GUARDIAN / FOSTER
NAME		
ADDRESS		
CITY/STATE/ZIP		
HOME PHONE	()	()
CELL PHONE	()	()
E-MAIL		
EMPLOYER		
WORK PHONE	()	()
PARENT EDUCATION LEVEL*	<input type="checkbox"/> NOT A HIGH SCHOOL GRADUATE <input type="checkbox"/> HIGH SCHOOL GRADUATE OR G.E.D <input type="checkbox"/> SOME COLLEGE, NO DEGREE RECEIVED <input type="checkbox"/> VOCATIONAL TRAINING SCHOOL <input type="checkbox"/> AA DEGREE - 2 YEAR COLLEGE DEGREE <input type="checkbox"/> COLLEGE DEGREE - 4 YEAR COLLEGE OR UNIVERSITY <input type="checkbox"/> GRADUATE SCHOOL/POST GRADUATE TRAINING <input type="checkbox"/> DECLINED TO STATE OR UNKNOWN	<input type="checkbox"/> NOT A HIGH SCHOOL GRADUATE <input type="checkbox"/> HIGH SCHOOL GRADUATE OR G.E.D <input type="checkbox"/> SOME COLLEGE, NO DEGREE RECEIVED <input type="checkbox"/> VOCATIONAL TRAINING SCHOOL <input type="checkbox"/> AA DEGREE - 2 YEAR COLLEGE DEGREE <input type="checkbox"/> COLLEGE DEGREE - 4 YEAR COLLEGE OR UNIVERSITY <input type="checkbox"/> GRADUATE SCHOOL/POST GRADUATE TRAINING <input type="checkbox"/> DECLINED TO STATE OR UNKNOWN
<small>*REQUIRED BY CDE</small>		

LIST THE NAME(S) OF ANYONE OTHER THAN PARENT WHO **HAS PERMISSION** TO PICK UP YOUR CHILD IN CASE OF EMERGENCY:

FULL NAME	RELATIONSHIP TO STUDENT	CONTACT PHONE#

LIST THE NAME(S) OF ANYONE YOU **DO NOT** GIVE PERMISSION TO PICK UP OR HAVE CONTACT WITH YOUR CHILD:

FULL NAME	RELATIONSHIP TO STUDENT

LIST THE NAMES OF OTHER CHILDREN LIVING AT HOME:

FULL NAME	RELATIONSHIP TO STUDENT	BIRTHDATE	GRADE IN SCHOOL

ETHNIC/RACIAL DATA (FEDERAL DATA REPORTING REQUIREMENT)

PART 1: IS THIS STUDENT HISPANIC OR LATINO?

<input type="checkbox"/> NO, NOT HISPANIC OR LATINO	<input type="checkbox"/> YES, HISPANIC OR LATINO
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PART 2: WHAT IS THE RACE OF THIS STUDENT? (SELECT ONE OR MORE)

<input type="checkbox"/> AMERICAN INDIAN OR ALASKAN	<input type="checkbox"/> TAHITIAN	<input type="checkbox"/> FILIPINO
<input type="checkbox"/> BLACK, AFRICAN AMERICAN	<input type="checkbox"/> OTHER PACIFIC ISLANDER	<input type="checkbox"/> KOREAN
<input type="checkbox"/> WHITE	<input type="checkbox"/> ASIAN INDIAN	<input type="checkbox"/> JAPANESE
<input type="checkbox"/> HAWAIIAN	<input type="checkbox"/> LAOTIAN	<input type="checkbox"/> VIETNAMESE
<input type="checkbox"/> GUAMANIAN	<input type="checkbox"/> CAMBODIAN	<input type="checkbox"/> HMONG
<input type="checkbox"/> SAMOAN	<input type="checkbox"/> CHINESE	<input type="checkbox"/> OTHER ASIAN

HOME LANGUAGE SURVEY (CALIFORNIA EDUCATION CODE REQUIREMENT)

WHICH LANGUAGE DID YOUR CHILD LEARN WHEN HE/SHE FIRST BEGAN TO TALK?	
WHAT LANGUAGE DOES YOUR CHILD MOST FREQUENTLY USE AT HOME?	
WHAT LANGUAGE DO YOU USE MOST FREQUENTLY TO SPEAK TO YOUR CHILD?	
NAME THE LANGUAGE MOST OFTEN SPOKEN BY THE ADULTS AT HOME.	

MY CHILD RECEIVES THE FOLLOWING SPECIAL SERVICES (CHECK ALL THAT APPLY)

<input type="checkbox"/> SPECIAL DAY CLASS	<input type="checkbox"/> GIFTED & TALENTED (GATE)	<input type="checkbox"/> SPEECH & LANGUAGE
<input type="checkbox"/> 504 PLAN	<input type="checkbox"/> RESOURCE SPECIALISTS (RSP)	<input type="checkbox"/> ENGLISH LEARNER

MEDICAL INFORMATION (CHECK ALL THAT APPLY)

<input type="checkbox"/> SPEECH IMPAIRED	<input type="checkbox"/> DIET RESTRICTIONS	<input type="checkbox"/> MEDICATIONS REQUIRED
<input type="checkbox"/> VISION IMPAIRED	<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> PHYSICAL RESTRICTIONS
<input type="checkbox"/> HEARING IMPAIRED	<input type="checkbox"/> DIABETES	<input type="checkbox"/> OTHER

FOR MEDICAL INFORMATION CHECKED ABOVE, PLEASE GIVE A BRIEF EXPLANATION _____

FAMILY DOCTOR _____ PHONE _____

HEALTH INSURANCE CARRIER _____ POLICY # _____

I, _____, THE UNDERSIGNED PARENT OR GUARDIAN OF _____

DO HEREBY AUTHORIZE THE LUCERNE ELEMENTARY SCHOOL DISTRICT OR ITS AUTHORIZED AGENT TO RETAIN THE SERVICES OF MY FAMILY PHYSICIAN, OR IF HE/SHE IS NOT AVAILABLE, ANY LICENSED PHYSICIAN, IN CASE OF EMERGENCY, ACCIDENT OR ILLNESS INVOLVING THE ABOVE NAMED CHILD. THIS AUTHORIZATION IS GIVEN WITHOUT RESERVATION. FOR THOSE STUDENTS COVERED BY MEDI-CAL; I HEREBY AUTHORIZE THE LUCERNE ELEMENTARY SCHOOL DISTRICT OR ITS AUTHORIZED AGENT TO BILL MEDI-CAL FOR MEDICAL SERVICES PROVIDED TO THOSE STUDENTS WHO RECEIVE MEDI-CAL BENEFITS.

SIGNATURE OF PARENT/GUARDIAN _____

DATE _____

<input type="checkbox"/> BIRTH CERTIFICATE <input type="checkbox"/> SHOT RECORDS <input type="checkbox"/> ENTERED
