



**Maxwell Unified School District
Registration/Emergency Form
(To be completed by the parent or guardian)**

Office Use Only:

Student I.D. No. _____
SSID No. _____

Anticipated Start Date: _____

Grade

Student's LEGAL Name: _____
(from birth certificate) Last Name First Name Middle Name Date of Birth: _____ Date _____ Mo./Day/Year Male Female

Residence Address City State Zip

Mother's/Guardian's First Name Last Name Home Phone Cell/Work Phone

Mother's Mailing Address City State Zip Mother's email address

Father's/Guardian's First Name Last Name Home Phone Cell/Work Phone

Father's Mailing Address (If Different) City State Zip Father's email address

CUSTODY ISSUES: Absent a copy of a court order, we will assume that both parents have custody of the child. If not, please provide the school the necessary information. Specific custody restrictions must be verified by providing the school a copy of the **LEGAL CUSTODIAL AGREEMENT**

Last School Attended: _____ Last Day of Attendance _____

Name of School City/State Phone No.

Student's Birthplace: _____ If not born in the U.S., what month/year did your child enter U.S.? _____ / _____

City/State/Country Mo./Year

What month and year did your child first enroll in a U.S. school? _____ / _____ In a California school? _____ / _____

Mo. / Year Mo. / Year

ETHNICITY: *Mark the ethnicity with which the student most closely identifies: Please check one:*

Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)
 Not Hispanic or Latino

Home Language: English Spanish Other Written Language: English Spanish Other

WHAT IS YOUR CHILD'S RACE (Please check up to five racial categories) The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

<input type="checkbox"/> American Indian or Alaskan Native (100) (Person having origins in any of the original people of North and South America (including Central America))	<input type="checkbox"/> Korean (203) <input type="checkbox"/> Vietnamese (204) <input type="checkbox"/> Asian Indian (205) <input type="checkbox"/> Laotian (206) <input type="checkbox"/> Cambodian (207) <input type="checkbox"/> Hmong (208)	<input type="checkbox"/> Hawaiian (301) <input type="checkbox"/> Guamanian (302) <input type="checkbox"/> Samoan (303) <input type="checkbox"/> Tahitian (304) <input type="checkbox"/> Other Pacific Islander (399) <input type="checkbox"/> Other Asian (299)	<input type="checkbox"/> African American or Black (600) <input type="checkbox"/> White (700) (Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)
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PARENT EDUCATION LEVEL: Check the response that describes the highest education level of parent/guardian(s):

Not a high school graduate Some college (includes AA degree) Graduate school/post graduate training
 High school graduate College graduate

What special services has your child received? (Please check all boxes that apply)

Special Education: Resource (RSP) Special Day Class (SDC) Speech/Language 504 Accommodation Plan
Other: Counseling English Language Development Medical Health Plan

Has the student been expelled or is the student in the process of being expelled from any school? Yes No

If yes: Name of school: _____ Location: _____ Date: _____

RESIDENCE – where is your child/family currently living? (Federally mandated: Please check appropriate box)

In parent/guardian's own home or apartment
 Temporarily living with another family
 At a campsite
 In a shelter
 Unaccompanied Youth/Foster Care or Group Home

In a motel/hotel
 Unsheltered (car/RV)
 In a transitional housing program
 Other location: _____

EMERGENCY CONTACTS: In the event of illness or suspension I hereby give my consent for my child to be released to the following person(s).
First and Last Name Relationship Home Phone Work Phone

OTHER CHILDREN IN THE FAMILY:

First and Last Name	Relationship	Lives at Home	School	Grade	Date of Birth
		Yes <input type="checkbox"/> No <input type="checkbox"/>			
		Yes <input type="checkbox"/> No <input type="checkbox"/>			
		Yes <input type="checkbox"/> No <input type="checkbox"/>			
		Yes <input type="checkbox"/> No <input type="checkbox"/>			

OTHER ADULTS IN THE HOME:

Name	Relationship	Name	Relationship
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HEALTH PROBLEMS (Check all that apply)

Diagnosed ADD or ADHD.....	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	Eye Injury.....	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Bladder Problems	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	Frequent Nosebleeds.....	<input type="checkbox"/>
Color Vision Deficiency.....	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>
Eczema/Skin Trouble.....	<input type="checkbox"/>	Chicken Pox.....	<input type="checkbox"/>
History of Ear Problem.....	<input type="checkbox"/>		
Known Hearing Loss.....	<input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>	
Known Vision Loss	<input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>	
Physical Limitations	<input type="checkbox"/>		
Wears Contact Lens	<input type="checkbox"/>		
Wears Glasses.....	<input type="checkbox"/>	For close work <input type="checkbox"/> For distance only <input type="checkbox"/> At all times <input type="checkbox"/>	

Other or further details of above _____

Medical Insurance: Company Name_____ Policy #_____
 Primary Care Physician_____ Phone Number_____

ALLERGIES (Check all that apply) None:

Animals <input type="checkbox"/>	Drugs <input type="checkbox"/>	List specific item(s) student is allergic to: _____
Insects <input type="checkbox"/>	Food <input type="checkbox"/>	
Bee Stings <input type="checkbox"/>	Plants <input type="checkbox"/>	Describe allergic reaction and/or treatment: _____
	Other <input type="checkbox"/>	Explain: _____

MEDIA PERMISSION

I/We give permission for my/our student to be observed, interviewed, photographed and/or filmed when a representative of the media have been permitted by the principal or designee to be on campus. Yes No

Expanded Learning Opportunities Program

I am/we are the parent/guardian of the above named student. I/we hereby authorize my/our child to be enrolled in the Expanded Learning Program (ELOP). I/we understand that by enrolling in the program, my/our child will have access to the before school program, after school program, summer camps, and all ELOP days and activities offered throughout the year. Yes No

EMERGENCY MEDICAL AUTHORIZATION

I am/we are the parent/guardian of the above named student. In case I am/we are unable to be reached during any emergency, I/we hereby authorize a representative of the school, pursuant to the provisions of Family Code Section 6910, to act as any agent to consent to the giving of any and all medical, dental, hospital or surgical care to the above named student. Yes No

I/We have reviewed this two page document and to the best of my/our knowledge, the information contained herein is true and complete. The undersigned declares under penalty of perjury that they are the parents or legal guardians of the above-named student and grant the above authorizations.

Date: _____ Signature of Parent/Guardian: _____

Email: _____