



PLEASE PROVIDE THE FOLLOWING FOR EACH STUDENT THAT YOU ARE REGISTERING:

1. **COMPLETED REGISTRATION PACKET**
2. **BIRTH CERTIFICATE**
3. **SHOT RECORDS** (Must be provided to the school nurse within 14 days of the enrollment date or the student **will be excluded** from school until records are provided.)
4. **PARENT/GUARDIAN'S DRIVERS LICENSE, PASSPORT, OR STATE I.D.**
5. **PROOF OF RESIDENCY** (**Current** Rental/Lease Agreement, Mortgage Statement, Settlement Statement, Deed, or Property Tax Statement)

(a)**If a parent/legal guardian's name does not appear on the proof of residency, the person whose name appears on the document, and is an established district resident must come with the parent/legal guardian to prove residency.

**If (a) above applies, any one of the following is required for additional proof of residency:

1. *Parent(s)' new Ohio drivers' license with current address*
 2. *Parent(s)' US Mail forward confirmation with new address*
 3. *Parent(s)' current Business mail received to new address*
6. **CUSTODY PAPERS** (Court stamped Divorce Decree with Shared Parenting Order, if Shared Parenting filed. Any modifications or Custody Orders relevant to child.)
 7. **IEP/MFE** (If applicable for Special Needs Students)

Student I.D. # _____
 School Building _____
 Home School _____
 1st Time in Ohio Schools Yes No

**FAIRFIELD CITY SCHOOLS
 STUDENT REGISTRATION
 KINDERGARTEN**

- Faxed
- Co-Resident
- ESL Gifted
- IEP Attached
- Trans. Form Attached

Please complete ALL sections below.

Entry Date: _____

Student's First Name		Middle		Student's Legal Last Name		Suffix	Grade		
Address (post office box is not acceptable as a residence address)				City	Zip	Home Phone #			
Cell #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	City of Birth		Citizenship <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Non U.S. Citizen/Immigrant				
Ethnicity <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Multi-Racial* <i>Please see note below:</i> <i>**Parents/Guardians who select multi-racial may also select 2 of the following racial elements:</i> <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White					Primary Language Spoken at Home: <input type="checkbox"/> English <input type="checkbox"/> Other: _____				
Has this student previously attended Fairfield City Schools? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, grade level and year at withdrawal: _____</i>				Is this student presently under expulsion or suspension: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please provide copies of paperwork.</i>					
Special Services (Special Education/Gifted Identification) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Is your child currently receiving any Special Education service(s), or, does your child currently have an I.E.P.?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Has your child been identified as gifted or did your child receive gifted services by a previous school district?</i>									
Previous School District/Building Attended				Previous School Address/City/State/Zip					
Status of Birth Parents <input type="checkbox"/> Both in Home <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Mother Deceased <input type="checkbox"/> Father Deceased									
Student Resides With <input type="checkbox"/> Biological or Adoptive Parents <input type="checkbox"/> Mother/Stepfather <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input type="checkbox"/> Grandparents <input type="checkbox"/> Father/Stepmother <input type="checkbox"/> Foster Family <input type="checkbox"/> Other: _____									
Biological/Adoptive Parent Information (required)									
MOTHER's First Name _____ Last Name _____ Maiden Name _____ Address (if different from student) _____ City/State/Zip _____ Cell # _____ Occupation _____ Place Employed _____ Business Phone # _____ Email Address _____				FATHER's First Name _____ Last Name _____ Address (if different from student) _____ City/State/Zip _____ Cell # _____ Occupation _____ Place Employed _____ Business Phone # _____ Email Address _____					
If mother and father's addresses are different, who has legal custody of child? _____									
In what state and county is court located where legal custody was granted? _____									
Legal Guardian (Other than Biological/Adoptive Parents) Name _____ Relationship _____ Email Address _____ Cell # _____ Occupation _____ Place Employed _____ Business # _____									
Step-Parent Information (if applicable) First Name _____ Last Name _____ Cell # _____ Occupation _____ Place Employed _____ Business Phone # _____									
Please list all persons living in the home									
Name		Sex	Age	Relationship to Child	Name		Sex	Age	Relationship to Child
_____		_____	_____	_____	_____		_____	_____	_____
_____		_____	_____	_____	_____		_____	_____	_____
_____		_____	_____	_____	_____		_____	_____	_____
I, the undersigned, do hereby state and declare under penalty of falsification (*) that I am the parent or legal guardian of the above named student and that this registration information is true and correct.									
Signature of Parent or Guardian _____				Relationship to Student _____		Date _____			
<i>*Falsification under Ohio Revised Code 2921.13 is a misdemeanor of the first degree punishable by a maximum of six (6) months imprisonment or a fine of \$1000.00 or both.</i>									

**FAIRFIELD CITY SCHOOL DISTRICT
HOME LANGUAGE SURVEY**

MUST BE COMPLETED BY ALL REGISTRANTS:

The information requested is mandated under Senate ORC Bill 140 and Education Management Information System (Sections 3301-0714)

STUDENT'S NAME: _____
(First Name) (Middle) (Last Name)

GENDER: Male Female **BIRTHDATE:** _____
(Month Day Year)

PLACE OF BIRTH: _____
(City of Birth) (State of Birth) (Country of Birth)

PARENT/GUARDIAN NAME: _____
(First Name) (Last Name)

HOME ADDRESS: _____
(Number and Street) (City/State) (Zip Code)

HOME PHONE # _____ **CELL PHONE#** _____

1. What language did your son/daughter speak when he or she first learned to talk? _____
2. What language does your son/daughter use most frequently at home? _____
3. What language do you use most frequently when speaking to your son/daughter? _____
4. What language do the adults at home most often speak? _____

If not born in the United States:

5. What year did your son/daughter first arrive in the United States? _____
6. How long has your son or daughter attended school in the United States? _____
7. My son/daughter began attending school in the United States on _____
(Month) (Date) (Year)
8. This is the first year for my son/daughter to attend school in the United States.

9. **IMMIGRANT YOUTH*:** Yes No

*To be considered an "immigrant youth", your child must meet *all three* of the following guidelines:

a) is aged 3-21; b) was NOT born in any U.S. State; c) has not attended school in any U.S. State for more than 3 full years.

Signature of Parent or Guardian _____

FOR SCHOOL DISTRICT PERSONNEL: If the answer to any of the first four questions above is a language other than English, indicate the student's native/home language in DASL and notify Curriculum Dept. ESL Secretary of new enrollment.

**FAIRFIELD CITY SCHOOL DISTRICT
STATEMENT OF RESIDENCY**

(Must be signed in the presence of a Fairfield City School District Official)

Parent/Guardian Information:

Date: _____

Parent Name: _____ Home Phone: _____ Cell: _____

Address: _____

(Street)

(City)

(Zip)

Legal Guardian of: _____ Residence is: Owned _____

(Child)

Rented/Leased _____

Place of Residence since: _____ Previous Address: _____

(Date)

Homeowner/Leaseholder: _____ Yes (Proceed to signature section below)

_____ No (Next section must be completed by homeowner/leaseholder)

Homeowner/Leaseholder Information

Date: _____

if Other than parent:

Homeowner/Leaseholder Name: _____ Phone: _____

Address: _____ Landlord Phone: _____

Date parent(s), and child moved to your residence: _____ Expected length of stay: _____

Reason for Co-Residency: _____

WARNING

I affirm that all information given above is true and correct. I agree that the Fairfield City Schools, if they deem necessary, have the right to investigate my residency. I agree to allow the release of rental information to a representative of the Fairfield Schools. I further understand and agree that, if it is later determined that this family is not a legal resident of Fairfield City Schools, such students will be withdrawn immediately from the Fairfield City School District.

A person who knowingly falsifies the above information is committing a first-degree misdemeanor, punishable by a maximum fine of \$1000.00 and/or a maximum term of imprisonment of six months. (Ohio Revised Code Section 2921.13)

Parent/Guardian Signature

Homeowner/Leaseholder Signature

Fairfield City School District Official Signature

Date

**FAIRFIELD CITY SCHOOL DISTRICT
HEALTH HISTORY FORM
(FOR KINDERGARTEN STUDENT)**

(Both sides of this form to be completed by parent or guardian.)

Child's Full Name _____
Last
First
Middle

Male Female Birthdate _____
Month
Day
Year

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 this infant's birth weight? _____

Did the infant have any sickness or problems while in the nursery?
 Yes No If yes, explain briefly _____

Development 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/her brothers/sisters or playmates?
 About the same _____ Slower _____ Faster _____

I. Health Conditions: Please check any that this child has had.

- | | |
|--|--|
| <input type="checkbox"/> Abnormal Spine Curvature (Scoliosis, etc.) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Allergies of Hay Fever | <input type="checkbox"/> Kidney Disease, type _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles ("old fashioned") |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Meningitis or Encephalitis |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Multiple ear infections (3 or more) |
| <input type="checkbox"/> Bedwetting at night | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Near drowning or near suffocation |
| <input type="checkbox"/> Birth/Congenital Malformation | <input type="checkbox"/> Nervous twitches/tics |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Chickenpox, date _____ | <input type="checkbox"/> Poor Hearing |
| <input type="checkbox"/> Chronic Diarrhea or Constipation | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Concern about relationship with siblings or friends | <input type="checkbox"/> Seizures or Epilepsy |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stool Soiling |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Substance Abuse (alcohol/drugs) |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Toothaches or dental infection (severe) |
| <input type="checkbox"/> Eye problems, poor vision | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Wetting during day |
| <input type="checkbox"/> Heart Disease, type _____ | |

II. Allergies – Please list and describe allergies or reactions to:

Medication/Drugs _____

Foods/Plants/Animals/Other _____

Recommended treatment if allergy is severe _____

III. Injuries and Illnesses – Please list any severe injuries or illnesses:

<u>Injuries/Illnesses</u>	<u>Age of Child</u>	<u>If Hospitalized (check)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 passive

Do you have any concern about how your child gets along with other children? _____

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

Completed by: _____ Relationship to child _____

**FAIRFIELD CITY SCHOOL DISTRICT
SCHOOL HEALTH RECORD (DOCTOR'S FORM)
RETURN THIS FORM TO THE SCHOOL AS SOON AS POSSIBLE**

Child's Name: _____ Mother's Name: _____

Address: _____ Father's Name: _____

Child's Date of Birth: _____ Male Female

IMMUNIZATION RECORD

Type	Date(s)				
DTP (4 or 5)*					
TD					
Polio (3 or 4)*					
MMR Combined (2)*					
Measles (Rubeola)					
Rubella					
Mumps					
H.I.B.					
Hepatitis B (3)*					
Varicella (2)*					
Other (Identify)					

*Immunization requirement of the Ohio Department of Health

T.B. Test Date _____ Negative _____ Positive _____

Tuberculin skin test is recommended prior to school entry, but not required.

SCREENING TESTS* (Optional)

Vision Date of Test _____ Distance Acuity R _____ L _____ Muscle Balance Pass <input type="checkbox"/> Fail <input type="checkbox"/> Color Pass <input type="checkbox"/> Fail <input type="checkbox"/> Wears glasses? Yes <input type="checkbox"/> No <input type="checkbox"/> Tested w/glasses? Yes <input type="checkbox"/> No <input type="checkbox"/> Referral made? Yes <input type="checkbox"/> No <input type="checkbox"/>	Hearing Date of Test _____ Audiometric thresholds: Rt. Ear Pass <input type="checkbox"/> Fail <input type="checkbox"/> Lt. Ear Pass <input type="checkbox"/> Fail <input type="checkbox"/> Other tests (specify) _____ Wears hearing aid? Yes <input type="checkbox"/> No <input type="checkbox"/> Tested with hearing aid? Yes <input type="checkbox"/> No <input type="checkbox"/> Referral made? Yes <input type="checkbox"/> No <input type="checkbox"/>	Speech/Language Speech Assessment Done _____ No discernible speech problem _____ Child has possible problem with: Articulation _____ Rhythm _____ Voice _____ Language _____ Speech evaluation recommended? Yes <input type="checkbox"/> No <input type="checkbox"/>
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PHYSICAL EXAMINATION

Date Examined _____ Essentially Normal _____

Height _____ (%) Weight _____ (%) B.P. _____ / _____

Abnormalities As Follows: _____

PHYSICIAN'S ASSESSMENT

<u>Problem List</u>	<u>Recommendation for School Management</u>
1. _____	_____
2. _____	_____
3. _____	_____

PLEASE PRINT OR STAMP:

Physician's Name: _____

Address: _____

Telephone Number: _____

Physician's Signature _____ Date Signed _____

**RETURN THIS FORM AS SOON AS POSSIBLE TO YOUR CHILD'S SCHOOL
OR THE NEW STUDENT WELCOME CENTER**

Dentist's Report

Return this form to the school as soon as possible

FAIRFIELD SCHOOL HEALTH RECORD

Child's Last Name First M.I. Father's Name

Child's Date of Birth Mother's Name

Male Female Child's Address _____

The following services have been performed:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Examination | <input type="checkbox"/> Oral prophylaxis |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Prescription for fluoride supplements |
| <input type="checkbox"/> Radiographs | <input type="checkbox"/> Topical application of fluoride |

The following oral hygiene instruction was provided:

- Tooth brushing
- Flossing
- Diet counseling reflecting relation of diet to dental health
- Home/school use of fluoride mouth rinse

The following statements are applicable:

- All necessary services have been performed
- No restorative services are required at this time
- Further treatment is indicated
- Further appointments have been arranged

COMMENTS: _____

PLEASE PRINT OR STAMP:

Dentist's Name _____

Address _____

Phone _____

Dentist's Signature _____ Date Signed _____

Return this form to the school as soon as possible