

2017-2018

Date: _____

TROY SCHOOL DISTRICT #287 STUDENT REGISTRATION FORM

TROY ELEMENTARY SCHOOL
103 TROJAN DRIVE
TROY ID 83871-0280
PHONE: 208-835-4261 FAX: 208-835-4250

TROY JR SR HIGH SCHOOL
101 TROJAN DRIVE
TROY ID 83871-0280
PHONE: 208-835-2361 FAX: 208-835-2441

Legal Name of Student _____ Nickname _____
Last First Middle

DOB ____/____/____ Place of Birth _____ Grade Level _____
CITY STATE

Circle Race (select one or more): *Hispanic or Latino* / American Indian or Alaska Native / *Asian* / African American / *Native Hawaiian or Other Pacific Islander* / White

Student Cell _____ **Student Email** _____

Mailing Address _____ City _____ Zip _____

Street Address _____ City _____ Zip _____

Parent/Guardian Name _____

Address _____

City _____ State _____ Zip _____ Home Phone # _____

Mother/Father/Guardian: Cell Phone # _____ Work Phone # _____

E-mail address _____

Place of employment: _____

Mother/Father/Guardian: Cell Phone # _____ Work Phone # _____

E-mail address _____

Place of employment: _____

Student lives with (check all that apply): ___ Mother ___ Father ___ Other: _____

List names & ages of siblings: _____

Are multiple families live at this address? ___ Yes ___ No

(Please fill out information on back)

Name of last school attended _____ Address _____

City _____ State _____ Zip _____ Phone# _____ Fax# _____

Does this student have a current IEP? **Yes/No**

Has this student had an IEP in the past? **Yes/No**

Does this student have a medical plan? **Yes/No**

IMPORTANT: List two (2) names of local people we may contact in the event of an emergency involving the student named above. School personnel will attempt to contact the parent/guardian first.

Emergency Name _____ Phone# _____

Emergency Name _____ Phone# _____

Doctor's Name _____ Phone# _____

Dentist's Name _____ Phone# _____

List student allergies and/or pertinent medical information

Please check any of the following that may apply to your child:

Arthritis

Hearing Aids

Physical Limitation-describe: _____

Asthma (Inhaler **YES/NO**)

Hearing Impairment

Bee Sting Allergy (Epi pen **YES/NO**)

Heart

Food Allergy-list: _____

Diabetes

Nuts (Epi pen **YES/NO**)

Glasses/Contacts

Seizures

Other: _____

Does student take daily medication(s)? Yes ___ No ___ If yes, please list medication(s) _____

Name of Insurance _____

In the event of an emergency involving the above named student, I request that the school contact me first. If I am unavailable, school personnel have my permission to seek emergency medical treatment, deemed necessary by a physician, for my child.

PARENT/GUARDIAN SIGNATURE