

Teacher: \_\_\_\_\_ ID #: \_\_\_\_\_

**COTTER ELEMENTARY SCHOOL Student Registration Information**      Date of Entry \_\_\_\_\_  
Grade \_\_\_\_\_

Name \_\_\_\_\_  
(First) (Middle) (Last)

Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender \_\_\_\_\_ Race \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Physical Address (if different from above): \_\_\_\_\_ City \_\_\_\_\_

Home Phone Number \_\_\_\_\_ How student gets to and from school \_\_\_\_\_  
Parent/Guardian E-Mail Address: \_\_\_\_\_  
Student's Cell Phone Number: \_\_\_\_\_

Student lives with (circle one): Both Parents    Mother Only    Father Only    Legal Guardian  
Mother/Stepfather    Father/Stepmother    Foster Parent    Other: \_\_\_\_\_  
Legal Custody (circle one): Both Parents    Mother Only    Father Only    Other: \_\_\_\_\_

**Are there any legal restrictions which would prevent your child from being checked out by a particular adult?    Yes or No      If YES, please provide the office with the legal documents.**

PLEASE NOTE THAT **ONLY THE PERSONS LISTED BELOW WILL BE ALLOWED TO CHECK THE STUDENT OUT OF SCHOOL. NO OTHER PERSON IS AUTHORIZED WITHOUT PARENT/GUARDIAN APPROVAL.**

**\*\*\*\*STUDENT LIVES WITH\*\*\*\***

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

**EMERGENCY INFORMATION**

Please list other people we can contact in the event the above are unavailable. These people will also be allowed to check your child out of school.

Name \_\_\_\_\_ Relation to Student \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation to Student \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**\*\*IS STUDENT A MILITARY DEPENDENT? (circle one)    Yes    No**

**\*\*IF SO (circle branch):**

- Active Duty: Coast Guard, Air Force, Army, Marines, Navy OR
- National Guard: Air Force, Army OR
- Reserves: Air Force, Army, Marines, Navy OR
- Parents serve in multiple branches (example: Mom-Army; Dad-Marines) \_\_\_\_\_

**\*\*DOES STUDENT RESIDE IN THE HOUSEHOLD OF THE SERVICE MEMBER: (circle one) Yes No**

**\*\*IS STUDENT PART OF A MULTIPLE BIRTH (twin, triplets, etc.)? (circle one) Yes No**

**\*\*ETHNICITY (circle one): Hispanic/Latino OR NON Hispanic/Latino**

**Home Language Survey:**

1. What language is spoken in your home most of the time? \_\_\_\_\_
2. What language does the student speak most of the time? \_\_\_\_\_
3. What language do parents speak most of the time? \_\_\_\_\_

**Does the student require special services? If yes, circle all that apply:**

Speech      Resource      Inclusion      504 Plan      Gifted and Talented

**Name, address, and phone number of last school attended:** \_\_\_\_\_

**Was student promoted to the next grade? (circle one) Yes No**

**Has student ever been retained? (circle one) Yes No**

**Has student been suspended or expelled from another school district? (circle one) Yes No**

**If yes, which school district:** \_\_\_\_\_

**IS STUDENT CURRENTLY SUSPENDED FROM ANOTHER SCHOOL:** \_\_\_\_\_

**IS STUDENT CURRENTLY UNDER ANY EXPULSION PROCEEDINGS:** \_\_\_\_\_

**If yes, which school district:** \_\_\_\_\_

**Has student ever been enrolled in Cotter School District: (circle one) Yes No**

**If yes, when did he/she last attend?** \_\_\_\_\_

**Any special circumstances the school should be aware of (recent divorce, death of a loved one, etc.)?** \_\_\_\_\_

**Transportation information:**

**Bus Rider** \_\_\_\_\_ **Car Rider** \_\_\_\_\_ **Afterschool** \_\_\_\_\_

**Address if riding bus:** \_\_\_\_\_

**Signature of parent or legal guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

## Cotter Public School Emergency Card

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_

Is Student on Medicaid or AR Kids? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list Medicaid number \_\_\_\_\_ AR kids number \_\_\_\_\_

### Parent/Guardian Contact information in case of accident/illness

Parent/Guardian name \_\_\_\_\_ Phone \_\_\_\_\_

Place of work/work number \_\_\_\_\_

Parent/Guardian name \_\_\_\_\_ Phone \_\_\_\_\_

Place of work/work number \_\_\_\_\_

### Emergency contacts if parent/guardian can't be reached

1. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Health Information: List any health conditions that your child has.

_____ ADHD	_____ Food Allergy	_____ High Blood Pressure
_____ Asthma	_____ Heart Disease	_____ Migraine Headache
_____ Bee Sting Allergy	_____ Heart Murmur	_____ Seizures
_____ Diabetes	_____ Hemophilia	_____ Vision Deficit
_____ Seasonal Allergy	_____ Hearing Deficit	_____ Other _____

I, the undersigned do hereby authorize officials of Cotter Public Schools to contact directly the persons named on this card and authorize the named physician to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event the parent/guardian cannot be contacted, the officials are hereby authorized to take whatever action is deemed necessary, in their judgement, for the health of aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child. Information on this form may be shared with appropriate personnel for health and educational purposes only.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



## Consent for "Over-the-Counter Medications"

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Medication Allergies \_\_\_\_\_

Medications your child takes on a regular basis: \_\_\_\_\_

**It is the parent's responsibility to send any medications that are frequently taken by your child to the school nurse.**

I give permission for my child, listed above, to receive these OTC medications as deemed necessary by the school nurse/designee. I understand that the generic equivalent may be used in place of brand named items. (Draw a line through any medication your child can not have.)

**For headache, fever, muscle aches, menstrual cramps:** Acetaminophen (Tylenol), Ibuprofen (Motrin), Muscle Rub (Icy Hot)

**For mild cold symptoms, sore throat, cough** Cough Drop, Daytime Cough Syrup

**For mild allergic reactions (such as hives, seasonal allergies):**  
Diphenhydramine (Benadryl)

**For mild skin irritations (such as rash, poison ivy, scrapes, cuts):**  
Antiseptic/Analgesic spray/gel/wash, Hydrocortisone Cream, Medcaine Swabs, Antibiotic Ointment, Antifungal Cream, Alcohol, Peroxide, Band-Aid

**For Stomachache:** Antacid (like Maalox or Tums), Pepto Bismal

**For Toothaches:** Oragel

**For Eye Irritations:** Visine, Sterile Eye Wash

**For Chapped Lips:** Carmex, Vaseline

**I acknowledge that the District, its Board of Directors, and employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this form. The nurse/designee shall administer medications.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

In compliance with the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. 1232g; 34 CFR Part 99)

I, \_\_\_\_\_, give permission for my child, \_\_\_\_\_  
(parent/guardian name) (First & last name)

Personally identifiable information/student education records to be disclosed to Cotter Public Schools for the purpose of billing Medicaid and/or private insurance.

I, also give permission for immunization information on my child to be released to Cotter Public School system for enrollment requirements.

Parent/Guardian Printed Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_