

THE SCHOOL BOARD OF HERNANDO COUNTY  
STUDENT REGISTRATION AND  
EMERGENCY CONTACT INFO

FOR OFFICE USE ONLY:  
TEACHER \_\_\_\_\_  
ENTRY DATE \_\_\_\_\_  
STUDENT ID # \_\_\_\_\_

PLEASE PRINT CLEARLY

\*\*\*\*\*

Date \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Student Legal Name: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_

Nickname \_\_\_\_\_ Date of Birth MM/DD/YYYY \_\_\_\_\_ Gender \_\_\_\_\_

Birth City \_\_\_\_\_ Birth State \_\_\_\_\_ Birth Country \_\_\_\_\_

Active Military Family Student: Yes or No \_\_\_\_\_ Student Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Optional)

R Hispanic/Latino Ethnicity? \_\_\_\_\_ Federal Race \_\_\_\_\_

Permission to distribute student demographic information including photo, interviews, website, video.

Public – Yes or No \_\_\_\_\_ Local (within the district/school) – Yes or No \_\_\_\_\_

Prior School \_\_\_\_\_ Prior School State \_\_\_\_\_ Prior School Country \_\_\_\_\_

Are you enrolling in our district due to either of these natural disasters? Earthquake \_\_\_\_\_ Hurricane \_\_\_\_\_ Neither \_\_\_\_\_

Has your child ever been retained? \_\_\_\_\_ If YES, which grade(s) \_\_\_\_\_

Has your child ever been enrolled in Special Education, Section 504 or remedial education program? Yes or No \_\_\_\_\_

Has your child ever been referred or received school-based mental health services? Yes or No \_\_\_\_\_

Has your child ever been enrolled in Hernando County Schools? Yes or No \_\_\_\_\_ If YES, Name of last school \_\_\_\_\_

Student Transportation (Walks, Pickup, Bus) \_\_\_\_\_ If Bus, Rt. Number \_\_\_\_\_

Indicate if you or your spouse is currently employed with Law Enforcement, Courts, DCF, Child Support Enforcement, or Fire Fighter. \_\_\_\_\_

Please list all school age siblings residing in the home who are enrolled in Hernando County Schools.

Sibling Name	School	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____

# FAMILY & EMERGENCY CONTACT INFORMATION

Student Name \_\_\_\_\_

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Residence Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Mailing Address **if different from above** \_\_\_\_\_

Parent/Guardian Name 1. \_\_\_\_\_ Relation to student \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Parent/Guardian Name 2. \_\_\_\_\_ Relation to student \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Student lives with: \_\_\_\_\_

If student does not live with parents, name/relationship of guardian \_\_\_\_\_

The enrolling parent/guardian **must provide** a certified court order indicating sole custody, or a restraining order, if they do not wish the other parent/guardian to have access to their child.

**For office use only: Order on file?** \_\_\_\_\_ **Staff member verifying receipt** \_\_\_\_\_

**Emergency Contacts:** It is **mandatory** that the emergency number/contact be provided. To serve your child in case of accident or sudden illness, it is necessary that you list those individuals **other than** the parent(s)/guardian(s) who are authorized to pick up your child through the clinic/office. (Example: Stepparent, Neighbor, Other Relative, Etc.)

	Name	Relation to student	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

# HEALTH INFORMATION

Student Name \_\_\_\_\_

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## MEDICAL INFORMATION:

Does your child have any of the following health conditions? (Check all that apply)

<input type="checkbox"/> Asthma (medication needed at school)	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Asthma (no medication needed at school)	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Wears Contacts/Glasses
<input type="checkbox"/> Allergy (Epi-pen required)	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Diabetes (Type 1)
<input type="checkbox"/> Allergy (No Epi-pen required)	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Diabetes (Type 2)
<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Other _____		

**You must contact the school health professional if the student has a health condition or requires care at school.**

Does your child require regular or emergency medication at school? \_\_\_\_\_

**If YES, a completed and signed Medication Authorization form must be submitted to the school if medication is required.**

Doctor's Name \_\_\_\_\_

Dr. Phone \_\_\_\_\_

Dentist's Name \_\_\_\_\_

Dr. Phone \_\_\_\_\_

**Notice of Fraudulent Documentation: Fraudulent documentation as defined is any information provided by the parent or other entity that falsely represents the parent's place of residence for school of enrollment. Whoever knowingly makes a false statement in writing with intent to mislead a public servant in the performance of his or her official duties, shall be guilty of a misdemeanor of the second degree, punishable by law (F. S. 837.06) or guilty of perjury by false written declaration, a felony of the third degree (F.S. 92.525).**

**I understand the above notice and have not provided any false information to a public servant.**

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date