FESSENDEN-BOWDON PUBLIC SCHOOL
PUPIL REGISTRATION INFORMATION

NAME OF STUDENT_____
LAST FIRST MIDDLE

MALE ( ) FEMALE ( ) RESIDENT ( ) NON-RESIDENT ( )

DISTRICT ENTRY GRADE LEVEL_____ DATE_____

BIRTHDATE _____ PLACE OF BIRTH _____

PHYSICAL ADDRESS _____
STREET CITY STATE ZIP

MAILING ADDRESS_____
(IF DIFFERENT FROM PHYSICAL ADDRESS)

HOME PHONE _____

ON BUS ROUTE: YES ( ) NO ( ) IF YES, PLEASE NOTE DIRECTION AND DISTANCE FROM SCHOOL

_____

STUDENT LIVES WITH MOTHER & FATHER ( ) MOTHER ( ) FATHER ( ) OTHER ( )

Is a language other than English spoken in the home? _____

If yes, please name and explain _____

NAME OF FATHER/GUARDIAN_____

OCCUPATION _____ CELL PHONE _____

WORK PHONE_____ EMAIL ADDRESS_____

NAME OF MOTHER/GUARDIAN _____

OCCUPATION _____ CELL PHONE _____

WORK PHONE_____ EMAIL ADDRESS_____

NAME AND ADDRESS OF SECOND PARENT (IF STUDENT INFORMATION IS TO BE SENT TO MORE THAN ONE ADDRESS)

_____

NAME

_____.

MAILING ADDRESS

Siblings (please list other children in the home):

Name	Birthdate	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SCHOOL LAST ATTENDED _____

(IF APPLICABLE) NAME OF SCHOOL

_____

ADDRESS OF SCHOOL

_____

PHONE/FAX NUMBERS

EMERGENCY CONTACT/MEDICAL

Has your child ever had a serious:

Sickness? _____ Date: _____ Describe: _____

Accident? _____ Date: _____ Describe: _____

Operation? _____ Date: _____ Describe: _____

Has your child ever had: Seizures, Convulsions, Periods of Unconsciousness or Prolonged High Fever?

_____

Has your child ever been examined by a specialist, other than a pediatrician? _____ If yes, please indicate:

Allergist	_____	Neurologist	_____
Optometrist	_____	Psychiatrist	_____
Ophthalmologist	_____	Psychologist	_____
Speech Pathologist	_____	Social Worker	_____
Ear-Nose-Throat M.D.	_____	Other	_____

If so, state name of Doctor, the date, and the diagnosis:

_____

_____

_____

In case of emergency, illness, or accident to the child named above the Fessenden-Bowdon School is authorized to proceed as indicated below.

Contact #1

_____ _____ _____
Name Relationship Phone Number

Contact #2

_____ _____ _____
Name Relationship Phone Number

Contact #3

_____ _____ _____
Name Relationship Phone Number

Contact Family Physician _____ _____
Name Phone Number

_____ Take Child to Emergency Hospital _____ Take Child to any Licensed Physician

Other Desired Procedures _____

_____

Signature of Parent or Guardian_____

Date_____

Student's Name _____

A. Please describe your child in terms of his temperament and attitudes. Also, in what way is your child like other children, or different from them? What words would best describe your child?

_____

_____

_____

_____

_____

_____

B. Now, describe what you expect or would like to have your child be like one year from now:

_____

_____

_____

_____

_____

_____