



# Le Roy Central School District

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2-6 Trigon Park  
Le Roy, New York 14482

Merritt Holly, Superintendent of Schools  
mholly@leroycsd.org

Phone (585) 768-8133  
Fax (585) 768-5505

## District Registration

Start Date \_\_\_\_\_

Student Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

DOB \_\_\_\_\_ Gender: M/F (circle one)

Ethnicity: \_\_\_\_\_ White (not Hispanic Origin) \_\_\_\_\_ American Indian or Alaska Native

\_\_\_\_\_ Asian \_\_\_\_\_ Black or African American

\_\_\_\_\_ Native Hawaiian/Other Pacific Islander

\_\_\_\_\_ Hispanic or Latino

Place of Birth: City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Student Residence Address 1 \_\_\_\_\_

Residence Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is your current address a temporary living arrangement? \_\_\_\_\_ Yes \_\_\_\_\_ No

Mother's Name: First \_\_\_\_\_ Last \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Address: \_\_\_\_\_

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

Father's Name: First \_\_\_\_\_ Last \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Address: \_\_\_\_\_

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

In an emergency (only if neither Parent is available) to call:

\_\_\_\_\_ Phone # \_\_\_\_\_

Step Parent or Legal Guardian: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name \_\_\_\_\_

Family physician to be called \_\_\_\_\_

Family dentist to call \_\_\_\_\_

**\*Please indicate below four different phone numbers, to be used in case of an emergency.**

Suggestions include the phone numbers for parent/guardian home, work, emergency, alternate neighbor, babysitter, etc. Be sure to indicate the full name and relationship for each phone number provided.

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

In case of early dismissal/emergency closing, please indicate below where your child should be sent:

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

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

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_

**Medication:** Is your child on daily medication? Yes \_\_\_\_\_ No \_\_\_\_\_

Is it necessary for this medication to be given during school hours?

Yes \_\_\_ No \_\_\_

If yes please obtain a special medication form from the school nurse. This form must be signed by the parent and the family physician, and kept on file in the school health office.

**Health Conditions:** List any know health conditions affecting the well-being and/or safety of your child: \_\_\_\_\_

Learning Impairment/Spec. Educ. needs: \_\_\_\_\_

List brothers and sisters in order of age:

Name:	Date of Birth	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of previous school attended (including nursery school)

\_\_\_\_\_

If the above named student should transfer out of Le Roy School District, authorization is hereby granted for LCSD to release information to the school district or facility concerning the above named student to which the student is transferring.

Signature: \_\_\_\_\_

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

Relationship: \_\_\_\_\_