Start Date:

FRANKLIN BOROUGH SCHOOL

50 Washington Avenue, Franklin, NJ 07416

973-827-9775 (phone) - 973-827-6522 (fax)

STUDENT PROFILE - REGISTRATION FORM

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	TODAY'S DATE
STREET ADDRESS			HOME PHONE ( )	CELL PHONE ( )
MAIL SHOULD BE ADDRESSED TO THE PERSON(S) LISTED BELOW:			GENDER BOY GIRL	GRADE TEACHER
MAILING ADDRESS			RACE (Optional) W B H AI A	PRIMARY LANGUAGE
NAME (CIRCLE ONE) MOTHER, STEPMOTHER, GUARDIAN		OCCUP. CELL # ( )		BUS. PHONE ( )
NAME (CIRCLE ONE) FATHER, STEPFATHER, GUARDIAN		OCCUP. CELL # ( )		BUS. PHONE ( )
EMERGENCY CONTACT #1 (**OTHER THAN PARENT) ****		PHONE ( ) CELL # ( )		RELATIONSHIP
EMERGENCY CONTACT #2 **(OTHER THAN PARENT) ****		PHONE ( ) CELL # ( )		RELATIONSHIP
CHILD'S DOCTOR			DOCTOR'S PHONE #	
NAME AND PHONE # OF LAST SCHOOL ATTENDED			HEALTH CONCERNS	
OTHER CHILDREN IN FAMILY (LIST BELOW):				

NAME	AGE	GRADE	NAME	AGE	GRADE	Child resides with:
						____ Both Parents
						____ Mother
						____ Father
						____ Guardian

** SOMEONE AUTHORIZED TO TRANSPORT/CARE FOR YOUR CHILD - **PLEASE NOTIFY SCHOOL OF ANY CHANGES.**

PLEASE CHECK ALL THAT APPLY:

____ I am the natural parent. ____ I have sole legal custody. ____ I have joint legal custody.

____ I am the adult the child is living with now. ____ I am a legal guardian. ____ I am a stepparent.

________ **I give my permission to release my child's photo and/or name for school-related activities.**

________ **I DO NOT give my permission to release my child's photo and/or name to the media for school-related activities.**

________ **However, I do GIVE my permission to publish my child's picture in the school yearbook.**

______________________________________ ____________________

Signature - Relationship to child **Date**

Please complete the reverse side.

CHILD'S NAME	DATE OF BIRTH

MEDICAL HISTORY

1. Please explain any history of serious illness, hospitalizations, or surgery. ___________________

   ____

2. Does the child have any allergies? ___________ Allergic to: _____________________________

3. Is the child on any medication? ____________ Current Medication _______________________

   May we share this information with your child's teachers? _______ Yes ______ No

4. Is there a history of any of the following?

• Multiple ear infections	____ yes	____ no
• Hearing problems	____ yes	____ no
• Visual problems	____ yes	____ no
• Speech problems	____ yes	____ no
• High blood pressure	____ yes	____ no
• Heart murmur	____ yes	____ no
• Asthma	____ yes	____ no
• Diabetes	____ yes	____ no
• Pneumonia	____ yes	____ no
• Chronic or recurrent stomach complaints	____ yes	____ no
• Kidney or bladder infections	____ yes	____ no
• Febrile (high temperature) convulsions	____ yes	____ no
• Epilepsy	____ yes	____ no
• Meningitis/Encephalitis	____ yes	____ no
• Head trauma causing concussion or loss of consciousness	____ yes	____ no
• Eating problems	____ yes	____ no
• Sleeping problems	____ yes	____ no
• Behavioral problems	____ yes	____ no

PLEASE GIVE DETAILS ON ANY OF THE ABOVE YES ANSWERS: _________________________

____

____

Child's City of Birth: ____________________________ State of Birth: ___________________

Country of Birth: _______________

____

Name of person completing this form (PLEASE PRINT)

____   ______________

OFFICE USE:
______ Proof of Residency ______ Birth Certificate ______ Immunizations