WHITESBORO CENTRAL SCHOOL DISTRICT

STUDENT REGISTRATION

This form is also available on our web site – http://www.wboro.org

1. INFORMATION ABOUT STUDENT

FAMILY NAME *(Last Name)*

DATE OF BIRTH *(mm/dd/yyyy)*

PRIMARY LANGUAGE

GIVEN NAME *(First Name)*

PLACE OF BIRTH *(City, State, Country)*

MIDDLE NAME

GENDER ☐Male ☐Female

FOSTER ☐Yes ☐No

MOBILE PHONE NO. *(Optional)*

IS THE STUDENT HISPANIC, LATINO, OR OF SPANISH ORIGIN? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

☐ YES, Hispanic
☐ NO, not Hispanic

SELECT ONE OR MORE RACES FROM THE FOLLOWING FIVE RACIAL GROUPS *[Check (√) all groups that apply to student; check (√) at least ONE box.]:*

- ☐ **AMERICAN INDIAN OR ALASKAN NATIVE**: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ☐ **ASIAN**: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **BLACK OR AFRICAN AMERICAN**: A person having origins in any of the Black racial groups of Africa.
- ☐ **WHITE**: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

2. LAST SCHOOL ATTENDED

LAST SCHOOL NAME

DATE LEFT *(mm/dd/yyyy)*

GRADE LEVEL

MAILING ADDRESS

CITY/TOWN/VILLAGE

STATE

ZIP CODE

3. INFORMATION ABOUT MEDICAL CARE

FIRST POLIO *(mm/dd/yyyy)*

NAME OF PHYSICIAN

BUSINESS PHONE NO.

MAILING ADDRESS

CITY/TOWN/VILLAGE

STATE

ZIP CODE

MEDICAL ALERTS

MEDICAL COMMENTS

4. INFORMATION ABOUT PRIMARY CONTACT

FAMILY NAME *(Last Name)*

RELATIONSHIP TO STUDENT

MOBILE PHONE NO. *(Optional)*

GIVEN NAME *(First Name)*

EMAIL ADDRESS *(Optional)*

HOME PHONE NO. *(Optional)*

HOME MAILING ADDRESS

CITY/TOWN/VILLAGE

STATE

ZIP CODE

EMPLOYER

OCCUPATION TITLE

BUSINESS PHONE NO. *(Optional)*

5. INFORMATION ABOUT ADDITIONAL CONTACT

FAMILY NAME *(Last Name)*	RELATIONSHIP TO STUDENT	MOBILE PHONE NO. *(Optional)*
GIVEN NAME *(First Name)*	EMAIL ADDRESS *(Optional)*	HOME PHONE NO. *(Optional)*
HOME MAILING ADDRESS	CITY/TOWN/VILLAGE	STATE / ZIP CODE
EMPLOYER	OCCUPATION TITLE	BUSINESS PHONE NO. *(Optional)*

6. INFORMATION ABOUT EMERGENCY CONTACT

FIRST CONTACT'S NAME *(Last Name, First Name)*	RELATIONSHIP TO STUDENT	PHONE NO. *(with Area Code)*
SECOND CONTACT'S NAME *(Last Name, First Name)*	RELATIONSHIP TO STUDENT	PHONE NO. *(with Area Code)*

7. INFORMATION ABOUT CHILDREN IN FAMILY

CHILD'S NAME *(Last Name, First Name)*	DATE OF BIRTH *(mm/dd/yyyy)*	SCHOOL NAME *(Optional)*
CHILD'S NAME *(Last Name, First Name)*	DATE OF BIRTH *(mm/dd/yyyy)*	SCHOOL NAME *(Optional)*
CHILD'S NAME *(Last Name, First Name)*	DATE OF BIRTH *(mm/dd/yyyy)*	SCHOOL NAME *(Optional)*

8. CERTIFICATION

To the Parent/Guardian: The information asked above is needed as a permanent school record of your child and will be used by school personnel. This is to certify the above information is correct. I, the undersigned, do hereby authorize officials of the school to contact directly the person named on this form, and do authorize the above named physician to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event physician, other person named on the form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

PRINT NAME HERE *(Print Name in Full)*	SIGN HERE *(Sign Name in Full)*	DATE

WHERE TO FILE

INSTRUCTIONS: Send this completed form to the address below that applies to you.

Deerfield Elementary 115 Schoolhouse Road Deerfield, NY 13502	Hart's Hill Elementary 8551 Clark Mills Road Whitesboro, NY 13492	Marcy Elementary 9479 Maynard Drive Marcy, NY 13403
Parkway School 65 Oriskany Boulevard Whitesboro, NY 13492	Westmoreland Road Elementary 8596 Westmoreland Road Whitesboro, NY 13492	Whitesboro CSD Office Post Office Box 304 Yorkville, NY 13495
Whitesboro High School 6000 State Route 291 Marcy, NY 13403	Whitesboro Middle School 75 Oriskany Boulevard Whitesboro, NY 13492	

CONFIDENTIALITY PROCEDURE AND REGULATION NOTICE

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below. The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.
To School Staff: This form will be filed in the student's permanent record as confidential information.

STOP! PLEASE DO NOT WRITE BELOW HERE

FOR OFFICE USE ONLY

Residency Verification Presented: (Yes / No) Student ID: (____________________________)

(Stamp Here)

Birth Certificate Presented: (Yes / No) Intake Initials: (________)