Milan Area Schools
Student Information Record

STUDENT INFORMATION

Student Name: _____
                Last Name   First   Middle

_____   _____
  Street Address   City   Zip

Grade Level: _____   Birth Date: _____   Place of Birth: _____
                              Mo/Day/Year   City/State

Gender   ☐ Male   School of Choice Yes ☐   Does the student currently have an active IEP? Yes ☐ No☐
           ☐ Female   No ☐   ***If yes, please provide a copy when registering**

Has your student ever been expelled from a previous district? Yes ☐   No ☐

Race or Ethnicity
It is federal regulation to report the ethnicity of students.

Please indicate Primary ethnic code _____   Secondary _____ _____ _____ _____ _____

1 American Indian / Native American   2 Asian American   3 Black / African American
4 Natural Hawaiian / Other Pacific Islander   5 White not of Hispanic Descent   6 Hispanic

FAMILY/CUSTODIAL INFORMATION

☐ Mother   ☐ Stepmother   ☐ Other_____   ☐ Father   ☐ Stepfather   ☐ Other_____

Name _____   Name _____

Email Address _____   Email Address _____

Place of Employment _____   Place of Employment _____

    ☐ _____ Home phone   ☐ _____ Home phone

    ☐ _____ Work phone   ☐ _____ Work phone

    ☐ _____ Cell phone   ☐ _____ Cell phone

Please indicate your preferred phone number by checking the box alongside

Please list other parent/guardian not living in your household who should receive a district mailings/report cards:

_____
Last Name   First Name   Phone Number

Health Concerns:

Please circle/check any health concerns your child may have:

___   Allergy to: Bee/Wasp, Eggs, Latex, Medication (please specify below), Milk, Peanuts, Soy, Tree Nuts, Wheat, Other (please specify below)   _____Student Uses an epi pen and/or Benadryl

___   Arthritis

___   Asthma   ____Uses an inhaler at school,

___   Cancer or history of cancer

___   Cardiac (please specify below)

___   Crohn's disease

___   Diabetic – Type 1

___   Diabetic – Type ll

___   Epileptic/Seizures

___   Hearing Impaired

___   Hemophiliac

___   Hypoglycemic

___   Kidney Disease

___   Migraine

___   No Blood Transfusions

___   Organ Transplant (please specify below)

___   Seizures

___   Ulcerative Colitis

___   Vision Impaired

Explanation

_____

_____

Doctor Name _____ Phone Number_____ Hospital_____

Emergency Contacts (other than parent):

_____   _____   _____
Name   Phone Number   Relationship to student

_____   _____   _____
Name   Phone Number   Relationship to student

_____   _____   _____
Name   Phone Number   Relationship to student

In the case of an accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow his/her instructions. If it is impossible to contact the physician, the school may make arrangements deemed necessary for the wellbeing of my child.

Parent or Guardian Signature _____ Date ____/____/____