



# Bismarck Public School District Student Registration Form

FAM ID#: \_\_\_\_\_

FOR OFFICE USE ONLY: \_\_\_\_\_ Student # \_\_\_\_\_ Initials of Recorder \_\_\_\_\_

## Section 1: Student Information

Student's Legal Name: \_\_\_\_\_  
(Last) (First) (Middle) (Preferred)

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Gender:  Male  Female

Has this student ever been suspended or expelled?  Yes  No Student's Cell Phone #: \_\_\_\_\_

Has this student previously attended a Bismarck Public School?  Yes  No

## Ethnic Category (Please mark primary one)

- American Indian/Alaskan Native  Asian  African American  Hispanic/Latino  
 Native Hawaiian/Other Pacific Islander  Caucasian

## Section 2: Medical/Emergency Information

In a case of a medical emergency and I cannot be reached, I give my child's doctor or any attending physician permission to administer medical treatment.  Yes  No

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Bismarck Public Schools (BPS) may give my child's Medicaid number to BPS health care providers so that the providers can bill Medicaid for services they provide my child. Medicaid # \_\_\_\_\_

Do not share my child's Medicaid Number with the school.  
 Does not apply – my child is covered by other insurance.  
 My child is not currently covered by any insurance.

## Health Information (Check ALL that apply)

- No known health problems  Contacts/Glasses  Hearing Aids  Ear Tubes  Frequent ear infections  
 Life threatening allergies (list) \_\_\_\_\_  Allergies (list) \_\_\_\_\_  
 Student requires Epi-pen at school  Yes  No Student requires rescue inhaler at school?  Yes  No  
 Asthma ( Inhaler Dependent)  Diabetic ( Insulin Dependent)  Seizures/Epilepsy ( Medication Required)  
 Student needs to take medication at school:  Yes  No Student has a medical condition school should be aware of:  Yes  No

## Section 3: Special Programs

Does this student have a current Individual Education Plan (IEP) through Special Education?  Yes  No

Does this student have a 504 Accommodation Plan (for such things as diabetes management, ADHD, etc.)?  Yes  No

Did this student participate in a Gifted and Talented Program at their last school?  Yes  No

Home Language (please indicate)  English  Other: \_\_\_\_\_

## Section 4: Additional Emergency Contacts

**Contact #1 (Last, First Name)** \_\_\_\_\_ Phone to contact during school hours \_\_\_\_\_  
 ( ) \_\_\_\_\_ - \_\_\_\_\_  Home  Cell  Work

Relationship:  Foster Parent  Guardian  Step-parent  Grandparent  Sibling  Custodian  Group Home  Other: \_\_\_\_\_

**Contact #2 (Last, First Name)** \_\_\_\_\_ Phone to contact during school hours \_\_\_\_\_  
 ( ) \_\_\_\_\_ - \_\_\_\_\_  Home  Cell  Work

Relationship:  Foster Parent  Guardian  Step-parent  Grandparent  Sibling  Custodian  Group Home  Other: \_\_\_\_\_

**Contact #3 (Last, First Name)** \_\_\_\_\_ Phone to contact during school hours \_\_\_\_\_  
 ( ) \_\_\_\_\_ - \_\_\_\_\_  Home  Cell  Work

Relationship:  Foster Parent  Guardian  Step-parent  Grandparent  Sibling  Custodian  Group Home  Other: \_\_\_\_\_

**Contact #4 (Last, First Name)** \_\_\_\_\_ Phone to contact during school hours \_\_\_\_\_  
 ( ) \_\_\_\_\_ - \_\_\_\_\_  Home  Cell  Work

Relationship:  Foster Parent  Guardian  Step-parent  Grandparent  Sibling  Custodian  Group Home  Other: \_\_\_\_\_

## Section 5: Parent/Guardian Signature

My relationship to the student is:

- Parent  Legal Guardian (Documentation Needed)  Person having lawful Court Order (Order Needed)  Other \_\_\_\_\_

I hereby certify that all the information contained in this form is true and accurate to the best of my knowledge.

Printed Name: \_\_\_\_\_

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