Bismarck Public School District
Student Registration Form (revised 12/2016)

FOR OFFICE USE ONLY:
School _____ Student # _____ Reg. ID # _____
Transportation Requested: Yes ___ AM Only PM Only AM/PM No ___

Student's Legal Last Name	First Name	Middle Name/Initial	Preferred Name

Date of Birth	Grade	Gender Male ___ Female ___	Student Cell Phone No.

Has this student previously attended a Bismarck Public School (including BECEP)? Yes ___ No ___

Has this student ever been suspended? Yes ___ No ___ | Has this student ever been expelled? Yes ___ No ___

Is this student a registered offender? Yes ___ No ___

Ethnic Category: Is this child Hispanic/Latino? Yes ___ No ___
Please choose all that apply to child's race: ___ African American ___ American Indian/Alaskan Native ___ Asian ___ Caucasian/White ___ Native Hawaiian/Other Pacific Islander

Medical/Emergency Information

In the 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's Name	Physician's Phone No.

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 No. _____

___ Do not share my child's Medicaid number with the school.
___ Does not apply – my child is covered by another 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 ___ Wheelchair
___ Life threatening allergies (list) _____ ___ Other allergies (list) _____
Student requires Epi-pen at school? Yes ___ No ___ ___ Student requires rescue inhaler at school? Yes ___ No ___
___ Asthma (___ Inhaler Dependent) ___Diabetes (___ Insulin Dependent) ___ Seizure/Epilepsy (___ Medication Required)
Student needs to take medication at school? Yes ___ No ___
Student has a medical condition school should be aware of? Yes ___ No ___ (Please list) _____

Special Programs

Does this student have a current Individual Education Plan (IEP) through Special Education? Yes ___ No ___
If yes, please indicate primary disability _____
Does this student have a 504 Accomodation 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: _____

Emergency Contacts – additional to parent/guardian

Contact #1 (Last, First Name)	Relationship to Child	Contact Phone No.
Contact #2 (Last, First Name)	Relationship to Child	Contact Phone No.
Contact #3 (Last, First Name)	Relationship to Child	Contact Phone No.

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

My relationship to the student is: ___ Parent ___ Legal Guardian (Documentation Needed)
___ Person having lawful Court Order (Order Needed) ___ Other _____

Printed Name: _____

Signature	Date