BUCKEYE CENTRAL MIDDLE SCHOOL
938 SOUTH KIBLER STREET
NEW WASHINGTON, OH 44854
TELEPHONE (419) 492-1035

Please print clearly (use pen if possible). Please respond to all questions.

** STUDENT REGISTRATION INFORMATION **

Date: _____

Student Name _____ Social Security# _____

Address _____
(Number) (Street) PO Box (If Applicable) (City) (Zip)

Telephone # _____ Sex: M ___F___ Birth Certificate Received _____ yes _____ no

Birthdate _____ Birth City _____ Birth State _____

Grade _____ Mother's Maiden Name _____ Native Language _____

Ethnicity: (Select One)
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race: (Select One or More)
☐ White ☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ _____

Previous School Attended _____

Address _____

_____

PARENTS(S)/LEGAL GUARDIAN INFORMATION

Student lives with: (circle one)
Father/Mother | Father/Stepmother | Mother
Stepfather/Mother | Legal Guardian | Father

Parent/Legal Guardian Name _____
(Copy of custody/guardianship papers must be provided at time of enrollment if applicable)

Cell Phone # _____ Cell Phone # _____ Cell Phone # _____

Father _____ Phone # _____
(Full Name) (Address)

Employed by _____ Phone # _____

Mother _____ Phone # _____
(Full Name) (Address)

Employed by _____ Phone # _____

Stepfather _____ Phone # _____
(Full Name) (Address)

Employed by _____ Phone # _____

Stepmother _____ Phone # _____
(Full Name) (Address)

Employed by _____ Phone # _____

Guardian _____ Phone # _____
(Full Name) (Address)

Employed by _____ Phone # _____

Over

BROTHERS AND/OR SISTERS :

Name _____ Birthdate _____ Grade _____

Name _____ Birthdate _____ Grade _____

Name _____ Birthdate _____ Grade _____

Name _____ Birthdate _____ Grade _____

Please check any special medical or disability problems you feel the school should be aware of:

MEDICAL ALERT CODES

1 Diabetic
2 Epileptic GM
3 Epileptic PM
4 Heart Condition
5 Nervous Disorder
6 Allergic to penicillin
7 Allertic to bee stings *
8 Allergies _____
9 Asthma
14 Emphysema
15 On medication _____ (type)
16 Ulcer
17 Hypoglycemia
18 Hemophiliac
19 Kidney Disorder
20 Nose Bleeds
21 Hay Fever

** If allergic to bee stings parents must provide the medication preferably 5 applications to last the school year.*

Other _____

EMERGENCY MEDICAL INFORMATION

Person to Contact _____ Phone _____

Alternate Contact _____ Phone _____

Hospital Requested _____ Phone _____

Doctor _____ Phone _____

STUDENT ON IEP NO YES on file not on file parent will provide

IMMUNIZATION RECORDS on file not on file parent will provide