BUCKEYE CENTRAL ELEMENTARY
938 SOUTH KIBLER STREET
NEW WASHINGTON, OH 44854
TELEPHONE (419) 492-1022

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

STUDENT INFORMATION

Date: _____

Student Name _____ Social Security# _____

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

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 Americ
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islande
☐ Asian ☐ _____

PARENTS(S)/LEGAL GUARDIAN INFORMATION

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

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

Father _____ Phone # _____
(Full Name) (Address)
Email Address _____
Employed by _____ Phone # _____

Mother _____ Phone # _____
(Full Name) (Address)
Email 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)
Email Address _____
Employed by _____ Phone # _____

Over

BROTHERS AND/OR SISTERS :

Name_____ Birthdate _____ Grade_____ Age _____

Name_____ Birthdate _____ Grade_____ Age _____

Name_____ Birthdate _____ Grade_____ Age _____

Name_____ Birthdate _____ Grade_____ Age _____

Medical Alerts:

Please Circle any Medical Conditions we need to be aware of:

Diabetic	Allergies	_____
Epileptic GM	Allergies to Food	_____
Epileptic PM	On Medication	_____
Heart Condition	Ulcer	Nose Bleeds
Nervous Disorder	Hypoglycemia	Hay Fever
Allergic Penicillin	Hemophiliac	ADHD
Alergic to Bee Stings	Kidney Disorder	Other _____

If allergic to bee stings or food parents must provide the medication.

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