



Bismarck Public Schools New Student Registration Form

Office Use Only:	
<input type="checkbox"/> Sent for records	<input type="checkbox"/> Birth Certificate
<input type="checkbox"/> Immunizations	
Student Number _____	Teacher _____
Previous School Attended _____	
Entry Date _____	Initials of Recorder _____

Person Completing Student Registration Form

Printed Name of Person Completing Form _____	Relationship to student _____
Signature of Person Completing Form _____	Date _____

Student Information

Last Name _____ First _____ Middle _____

Preferred Name (if different than above) _____

Home Phone _____ Gender M F Grade Level _____

Date of Birth _____ Language Spoken at Home _____

Ethnicity (circle one): American Indian Caucasian African American
 Hispanic Asian Pacific Islander

Address Information

***School and District mailings will be sent to the address indicated in Student Mailing Address**

*Student Mailing Address _____ City _____ State _____ Zip _____

Street Address (if different) _____ City _____ State _____ Zip _____

Parent Information

Father's Name _____ Home Phone _____ Cell Phone _____

Father's Employer _____ Work or Day Phone _____

Father's Street Address (if different than Student) _____

Mother's Name _____ Home Phone _____ Cell Phone _____

Mother's Employer _____ Work or Day Phone _____

Mother's Street Address (if different than Student) _____

Living Arrangements

Does this child live in a single-parent household? Yes No

Student currently lives with: Both Parents Mother Only
 Father Only Other _____

If student currently has a Step-Parent; Guardian; Foster Parent; Custodian; Group Home; etc; indicate the name, relationship, and phone numbers.

Name 1 _____ Relationship _____

Home or Day Phone _____ Cell Phone _____

Name 2 _____ Relationship _____

Home or Day Phone _____ Cell Phone _____

Emergency Information (Indicate a Local contact – Other than Parent)

Contact 1 _____ Relationship _____

Daytime Phone _____ Type of Phone: Home Work Cell

Contact 2 _____ Relationship _____

Daytime Phone _____ Type of Phone: Home Work Cell

Medical Information

Doctor _____ Phone _____

Life threatening allergies (list) _____

Other Allergies (list) _____

Will this student have an Epi-pen at school? Yes No

Will this student have a rescue inhaler at school? Yes No

Medications (list type and purpose) _____

Health Conditions (circle and describe any that apply):

Contacts/Glasses Diabetes Seizures Frequent Ear Infections

Hearing Aids Ear Tubes Asthma

Other/List _____

This Section should be Completed by Student’s Legal Decision Maker

Is this Student the Youngest Family Member enrolled in this School? Yes No

Is this Student the Youngest Family Member enrolled in this District? Yes No

Has your child ever received Special Education, Title I, or 504 services? Yes No

If “yes”, indicate dates, school district, and which service(s) _____

In 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

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 Number _____

I do not wish to 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

Has your child ever been suspended or expelled from school? Yes No

If yes, give date, school, incident: _____

Please provide an email address where you can be contacted (PLEASE PRINT):

Please return this completed form to the school office.

If there is any additional information about the health and welfare of your child of which the school needs to be aware, please contact the school office directly.