



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. _____	<input type="checkbox"/> Do not share my child's Medicaid number with the school. <input type="checkbox"/> Does not apply – my child is covered by another insurance. <input type="checkbox"/> My child is not currently covered by any insurance.	

Health Information (Check ALL that apply)

No known health problems
 Ear Tubes
 Life threatening allergies (list) _____
 Student requires Epi-pen 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) _____

Contacts/Glasses
 Frequent Ear Infections
 Other allergies (list) _____
 Hearing Aids
 Wheelchair
 Student requires rescue inhaler at school? Yes ___ No ___

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 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: _____

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
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