Berkeley Unified School District Student Registration Form

School | Grade | Year 20 _____

Directions: Please print in ink. Press Firmly. Do not write in shaded areas.

Student's Legal Last Name	First	Middle	Birthdate ___/___/___	Gender M☐ F☐ NB☐

Student's Birthplace (city, state, country)

Date and grade student first entered Berkeley Unified Schools

Date: _____/_____/_____ Grade: _____

Parent/Guardian Name	Home Number	Cell Phone	Work Number	Email Address
Parent/Guardian Name	Home Number	Cell Phone	Work Number	Email Address

For students not born in the United States

Exchange student or child of visiting scholar? Yes☐ No☐

Date of entry into the U.S. (mm/dd/yy) _____

Date first entered a U.S. school K-12 (mm/dd/yy) _____

Does your child have an IEP with special education? Yes☐ No☐

Date of most recent IEP: _____

Does your child have a 504 plan? Yes☐ No☐

Most recent school name | Date of attendance

Address	City	State	Phone Number

Previous school name | Date of attendance

Address	City	State	Phone Number

Sibling(s) Names	Age	School Attending	Live in same home?

I certify that all of the information is correct to the best of my knowledge.

_____

Parent/Guardian Signature Date

Health Coverage

- ☐ Alliance (non Medi-Cal)
- ☐ Blue Cross
- ☐ Health Net
- ☐ Healthy Families
- ☐ Kaiser (non Medi-Cal)
- ☐ Medi-Cal Alliance
- ☐ Medi-Cal Blue Cross
- ☐ Other_____
- ☐ None

FOR SCHOOL USE

Entrance Date
Month Day Year

Status
New this year
In State
Out of state
Returned

Grade	Room	Teacher

Student ID Number

Birth Verification

Records Requested
Month Day Year

Immunization
☐ Completed ☐ In Process

STUDENT EMERGENCY CARD
Berkeley Unified School District

Medical Alert ☐

STUDENT First Name		Last Name		
Middle Name	Birthdate	Grade	Room Number	Teacher
Home Address (Not updated by school) City Zip		Mailing Address City Zip		

PARENT - GUARDIAN

Parent 1/Guardian 1	Home Phone	Parent 2/Guardian 2	Home Phone
Daytime Phone	Cell Phone	Daytime Phone	Cell Phone
E-mail address		E-mail address	
Employer Name/City		Employer Name/City	

Does someone other than the Parent/Guardian provide afterschool care for your child? ☐ No ☐ Yes ☐ LEARNS ☐ BEARS ☐ Other

Name	Phone	Daily or: Mo Tu We Th Fr (circle d[illegible])	Student takes the SCHOOL BUS afterschool ☐

EMERGENCY CONTACTS

List local emergency guardians who have *agreed to take responsibility* for picking up and providing either temporary or extended care of your child in case of illness, minor injury or a natural disaster if a parent or primary guardian cannot be reached:

Name(s)	Phone	Alternate Phone	Relationship
Emergency third party phone contact outside of the Bay Area who can be contacted in the event of a local disaster:			

HEALTH & MEDICAL

Health concerns: ☐ **Asthma** ☐ **Allergies** ☐ **Diabetes** ☐ **Seizures** ☐ **Other:**

Medications to be taken at school require a ***physician-signed*** **Medication Authorization Form.** Forms are available from the school office or district website. List all—including emergency—medications:

Physician	Phone	Address
Health Plan Provider	Member Number	Group Number
Dentist	Phone	Address

I, the undersigned legal parent or guardian of the student shown above, a minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care to be rendered under the general or special supervision and upon the advise of a physician, surgeon, or dentist under the provisions of the Medical Practice Act, or Dental Practice Act. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care but is given to provide authority and power for the physician/dentist to render care which in his/her best judgement may be deemed advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

It is the responsibility of the parent/guardian to immediately notify the school in writing of any changes in the information on this card. A new card must be completed every school year.

PARENT/GUARDIAN SIGNATURE **DATE**

Official Use Only	To be completed ONLY when releasing a child to an emergency guardian or medical personnel following a natural disaster.	
Student released to	Date/Time	Student release coordinator's signature

MEDICAL HISTORY - Berkeley High School/B-Tech Health Center

(This needs to be filled out and signed by the student's parent or guardian)

PLEASE ATTACH A COPY OF STUDENT'S IMMUNIZATION RECORDS

Student's name: _____ Birthdate: _____ Gender ☐ ☐

Parent/Guardian's name: _____Relationship to student: _____

Address: _____

Phone: Home: _____Work: _____ Cell: _____

Emergency Contact (name/phone): _____

Health Insurance: _____

Name of primary medical provider: _____ Phone #: _____

We have no health insurance: ☐ We would like help obtaining insurance for this student: Ye ☐ No ☐

1. Is this student allergic to any medications? Yes ☐ No ☐ If yes, give name of medication and describe reaction:

_____

2. List any medication(s) student is taking now and the problem it is treating.

Medication: Dose: Reason:

_____ _____ _____

_____ _____ _____

3. Has student ever been hospitalized overnight? Yes ☐ No ☐ If yes, give the age at time of hospitalization and describe the problem: _____

4. Has student had any serious injuries? Yes ☐ No ☐ If yes, please give age at time of injury and describe the injury.

_____

Please check (√) whether **this student** has ever had any of the following health problems.

	Yes	No		Yes	No		Yes	No
Allergies……	☐	☐	Ear infections …….	☐	☐	Mononucleosis…….	☐	☐
Anemia…….	☐	☐	Fainting …….	☐	☐	Pneumonia……	☐	☐
Blood disorders……	☐	☐	Food allergy causing hives	☐	☐	Rheumatic fever……	☐	☐
Asthma ……	☐	☐	Migraines……	☐	☐	Scoliosis……	☐	☐
Bladder disease……	☐	☐	Hearing impairment ……	☐	☐	Seizures…… …	☐	☐
Kidney disease…….	☐	☐	Heart murmur……..	☐	☐	Sickle cell anemia	☐	☐
Blood clots/phlebitis……	☐	☐	Hernia…….	☐	☐	Thyroid disease……	☐	☐
Cancer…….....	☐	☐	Hepatitis…….....	☐	☐	Tuberculosis……	☐	☐
Depression ……..…	☐	☐	High blood pressure……	☐	☐			
Diabetes ……..	☐	☐	High cholesterol……	☐	☐			
Chicken pox……	☐	☐	Mental Health Diagnosis	☐	☐			

Explain conditions checked ***yes*** above (age onset, treatment, current status, etc) :

_____

_____

Family health history: Have any of this student's blood relatives (parents, siblings, aunts, uncles, grandparents) living or deceased, had any of the following problems?

	Yes	No	Who		Yes	No	Who
Alcoholism…….	☐	☐	_____	Heart attack/stroke **after** age 55…	☐	☐	_____
Substance Abuse: type_____	☐	☐	_____	High blood pressure ……	☐	☐	_____
Allergies……..……..	☐	☐	_____	High cholesterol ……..	☐	☐	_____
Asthma……	☐	☐	_____	Lung disease…….……	☐	☐	_____
Birth defects ……..	☐	☐	_____	Mental health/Depression……..…	☐	☐	_____
Blood disorders ……	☐	☐	_____	Seizures……	☐	☐	_____
Cancer: type _____	☐	☐	_____	Smoking …….	☐	☐	_____
Diabetes ……	☐	☐	_____	Tuberculosis…….	☐	☐	_____
Heart attack/stroke **before** age 55	☐	☐	_____	Other: _____			

Parent/Guardian Signature: _____ **Date**_____

**************************DON"T FORGET TO ALSO SIGN THE PREVIOUS CONSENT PAGE**************************