McCloud Union School District

Shelley Cain, Superintendent-Principal
P.O. Box 700 McCloud, California 96057 530-964-2133 FAX 530-964-2153

School Year: _____

Student Name: _____
Last Name *First Name* *Middle Name or Initial* *aka*

Male / Female *Circle One* **Grade:** _____ **Birth Date:** ____/____/_____ **Birthplace:** _____
City *State* *Country*

Lives With: ___Father ____ Mother ____ Stepfather ____ Stepmother ___ Other: _____

Parent/Guardian Name *Relationship* *Home Phone*

Work Phone *Cell Phone* *Email Address*

Parent/Guardian Name *Relationship* *Home Phone*

Work Phone *Cell Phone* *Email Address*

Mailing Address: _____
Street / PO Box *City* *State* *Zip Code*

Residence Address: _____
(If different from above) *Street / PO Box* *City* *State* *Zip Code*

What is your child's ethnicity? *(Please check one)* O Hispanic or Latino O Not Hispanic or Latino *(Regardless, complete race section)*

Race: *(Choose the group with which the student most closely identifies.)*

- O American Indian/Alaska Native (100)
- O Asian Indian (205)
- O Black/African American (600)
- O Cambodian (207)
- O Chinese (201)
- O Filipino/Filipino American (404)
- O Guamanian (302)
- O Hawaiian (301)
- O Japanese (202)
- O Korean (203)
- O Laotian (206)
- O Other Asian (299)
- O Pacific Islander (399)
- O Samoan (303)
- O Tahitian (304)
- O Vietnamese (204)
- O White (Not Hispanic) (700)

Primary Home Language:

- O Arabic (11)
- O Armenian (12)
- O Cantonese (03)
- O English (00)
- O Farsi (16)
- O Filipino (05)
- O French (17)
- O German (18)
- O Hindi (22)
- O Hmong (23)
- O Japanese (08)
- O Khmer (09)
- O Korean (04)
- O Lao (10)
- O Mandarin (07)
- O Punjabi (28)
- O Russian (29)
- O Samoan (30)
- O Spanish (01)
- O Taiwanese (46)
- O Thai (32)
- O Ukrainian (38)
- O Urdu (35)
- O Vietnamese (02)
- O Other: _____(99)

Has your child ever been retained? Yes / No If yes, what grade? _____

Has your child ever been expelled? Yes / No If yes, what year? _____ What school? _____

Special Services: ___RSP ___Speech ___GATE ___504 Plan ___Behavior Plan

Parent Education: Highest level of education of father

____Not High School Graduate ____ High School Graduate/GED ____Some College/AA ____College Graduate ____Graduate School/Post Graduate

Parent Education: Highest level of education of mother

____Not High School Graduate ____ High School Graduate/GED ____Some College/AA ____College Graduate ____Graduate School/Post Graduate

Duplicate Mailing: ____ Father ____ Mother *(If divorced/separated & joint custody allows duplicate mailing/information to be given to other parent, please include their name, address, and telephone number.)*

Full Name *Home Phone* *Cell Phone* *Work Phone*

Street / PO Box *City* *Zip Code*

EMERGENCY CONTACTS: *(Other than above. Parent/guardian will be contacted first.)*

Full Name	Phone/Cell Number	Relationship to student	Release OK: Yes / No (Circle One)

COURT ORDERS: *(If you have a court order please make sure the office has a copy of it on file.)*

List Order(s): _____

Health Conditions: ____ Asthma ____ Epilepsy ____Diabetes ____ Heart Problems ____Seizures ____ Bee Allergies
____ Food Allergies *(If this is checked, please fill out the Medical Statement for Participants with Allergies/Chronic Diseases form.)*

Does your child take medication regularly? Yes / No *If yes, what kind?* _____
Does your child have a speech problem? Yes / No *Please explain:* _____
Does your child have an ear problem? Yes / No *If yes, what kind?* _____
Does your child have a physical handicap? Yes / No *Please explain:* _____
Does your child have an eye problem? Yes / No *Please explain:* _____

We will ALWAYS try to contact parents or contacts before a student will be transported for emergency medical treatment

Doctor's Name: _____ Phone Number: _____
Dentist's Name: _____ Phone Number: _____
Hospital Name: _____ Phone Number: _____

Does your child have health insurance? _____ Yes _____ No
If no you may be eligible for free or low cost insurance through Medi-Cal or Covered California
Please check with the School office to get more information or assistance in obtaining health coverage

Medical Insurance Co./Group Number: _____

____I **DO NOT** wish medical care secured for my child because of religious/personal beliefs. Please Explain: _____

I hereby authorize the staff of McCloud Union Elementary School District to secure and sign for emergency medical care for my child at my expense, when necessary

_____
Parent's Signature *Date*

According to appropriate grade level schedules, all children will receive vision, hearing, dental, scoliosis, speech and language screening. You have the right to refuse these services for your child. Unless you notify the office in writing, your child will be screened at no expense to you.