Milan Area Schools
Student Information Record

STUDENT INFORMATION

Student Name: _____
Last Name First Middle

_____ _____ _____
Street Address City Zip County

Grade Level: _____ Birth Date: _____ Place of Birth: _____
Mo/Day/Year City/State/Country

_____
If born outside the U.S., What is the student's date of entry in to the United States?

Gender ☐ Male ☐ Female School of Choice Yes ☐ No ☐

Does the student currently have an active IEP? Yes ☐ No ☐
***If yes, please provide a copy when registering**

Is your student receiving Speech Therapy? Yes ☐ No ☐

Has your student ever been expelled from a previous district? Yes ☐ No ☐

Have you ever been enrolled in Milan Area Schools? Yes ☐ No ☐

Race or Ethnicity
It is federal regulation to report the ethnicity of students.

Please indicate Primary ethnic code _____ Secondary _____ _____ _____ _____ _____

1 American Indian / Native American
2 Asian American
3 Black / African American
4 Natural Hawaiian / Other Pacific Islander
5 White not of Hispanic Descent
6 Hispanic

FAMILY/CUSTODIAL INFORMATION

Birth Mother

Name _____

Email Address _____

Place of Employment _____

☐ _____ Home phone
☐ _____ Work phone
☐ _____ Cell phone

Birth Father

Name _____

Email Address _____

Place of Employment _____

☐ _____ Home phone
☐ _____ Work phone
☐ _____ Cell phone

Please indicate your primary phone number by checking the box alongside

Step Parent / Other person living in your household.

_____ _____ _____
Name Cell Phone Work phone

Health Concerns:

Please circle/check any health concerns your child may have:

___ Allergy to: Bee/Wasp, Eggs, Latex, Medication (please specify below), Milk, Peanuts, Soy, Tree Nuts, Wheat, Other (please specify below) _____Student Uses an epi pen and/or Benadryl

___ Arthritis

___ Asthma ____Uses an inhaler at school,

___ Cancer or history of cancer

___ Cardiac (please specify below)

___ Crohn's disease

___ Diabetic – Type 1

___ Diabetic – Type ll

___ Epileptic/Seizures

___ Hearing Impaired

___ Hemophiliac

___ Hypoglycemic

___ Kidney Disease

___ Migraine

___ No Blood Transfusions

___ Organ Transplant (please specify below)

___ Seizures

___ Ulcerative Colitis

___ Vision Impaired

Explanation

_____

_____

Doctor Name _____ Phone Number_____ Hospital_____

Emergency Contacts (other than parent):

_____	_____	_____
Name	Phone Number	Relationship to student
_____	_____	_____
Name	Phone Number	Relationship to student
_____	_____	_____
Name	Phone Number	Relationship to student

In the case of an accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow his/her instructions. If it is impossible to contact the physician, the school may make arrangements deemed necessary for the wellbeing of my child.

Parent or Guardian Signature _____ Date ____/____/____