Sacramento City Unified School District

Please email your completed form to:
didionoffice@scusd.edu

For Office Use Only

Student ID # _____
School Year _____

DEMOGRAPHIC INFORMATION

Student Legal Last Name	Legal First Name	Legal Middle Name	Gender	Grade	DOB
			☐ Male ☐ Female		

Nickname:	Preferred Gender Pronoun:	Previous School Attended:

TRANSPORTATION AND RELATED INFORMATION

Check the boxes below if your child rides the bus.
☐ To School ☐ From School Bus # _____

Daycare Provider: _____
Phone #1: _____ Phone #2: _____

PARENT EDUCATION: Check the box that best describes the highest education level of either parent/guardian.

☐ Not a High School Graduate ☐ High School Graduate ☐ Some College (includes AA degrees)
☐ College Graduate ☐ Graduate Degree or Higher

PRIMARY HOUSEHOLD: *This is the address where the student **primarily** lives.*

Primary Household Address:

Parent/Guardian 1	Full Legal Name:		DOB:	Email:
Home Phone:		Cell Phone:		Work Phone:
Other adult in household	Legal Name:		DOB:	Email:
		Cell Phone:		Work Phone:

SECONDARY HOUSEHOLD: **Complete the address section **ONLY** if the parents **do not** live in the same household.*

Secondary Household Address:

Parent/Guardian 2	Full Legal Name:		DOB:	Email:
Home Phone:		Cell Phone:		Work Phone:
Other adult in household	Legal Name:		DOB:	Email:
		Cell Phone:		Work Phone:

AUTOMATED MESSENGER CONTACT INFORMATION: Check to *receive automated messages*.

	Attendance	Behavior	General	Teacher	Priority
Primary Guardian's Email Address	☑	☑	☑	☑	☑
Primary Guardian's Home Phone	☐	☐	☐	☐	☐
Primary Guardian's Cell Phone	☑	☑	☑	☑	☑
Primary Guardian's Work Phone	☐	☐	☐	☐	☐
Secondary Guardian's Email Address	☑	☑	☑	☑	☑
Secondary Guardian's Home Phone	☐	☐	☐	☐	☐
Secondary Guardian's Cell Phone	☑	☑	☑	☑	☑
Secondary Guardian's Work Phone	☐	☐	☐	☐	☐

NON-HOUSEHOLD EMERGENCY CONTACTS: List people who can check your child out of school.

Name:	DOB:	Relationship to Student	Primary Phone Number:
Name:	DOB:	Relationship to Student	Primary Phone Number:
Name:	DOB:	Relationship to Student	Primary Phone Number:

PLEASE READ: California Education Code 49408 states that school districts can require that emergency information be kept current. Parent/guardian is responsible for notifying the school, in writing, of telephone or address changes with three (3) days of occurrence. If the school is unable to reach anyone on this form in an emergency or if a student is left unattended during non-school hours, the school will contact law enforcement or Child Protective Services.

Parent/Guardian initials: _____

HEALTH AND EMERGENCY INFORMATION

☐ **Check here if student has NO KNOWN HEALTH PROBLEMS.**

☐ **Check here if student has KNOWN HEALTH PROBLEMS and check all that apply below.**

☐ ADD/ADHD ☐ Heart Problems ☐ Seizures

☐ Asthma ☐ Diabetes ___Type I___Type II

☐ SEVERE Allergy to:_____ ☐Other: _____

☐ Epi-Pen

☐ Check here if student wears glasses/contact lenses.	☐ Check here if student has hearing loss or uses hearing aids.

Does student have a condition that limits participation in: ☐ Classroom ☐ Physical Education

Explain:

List all medications (including dosage) taken by your child and indicate whether medication is needed at home, school, or both. *Note: California Education Code 49423 requires that if medications are to be taken at school, there must be a medication form on file at school, signed by both parents and physician. Parent or guardian shall inform the school nurse or designated certificated employee of the medication being taken.*

AT HOME _____

AT SCHOOL _____

WHAT SPECIAL SERVICES DOES YOUR CHILD RECEIVE? (Check all boxes that apply)

☐ Resource (RSP) ☐ 504 ☐ Speech & Language ☐ Gifted (GATE)

☐ Special Day Class (SDC) ☐ IEP ☐ English Learner Support ☐ NONE

Special Instructions/Comments (Medical 504 Plan, special health needs, emergency care plan, etc.):

EMERGENCY AUTHORIZATION

In the event of an emergency, when a parent/guardian is unavailable, I authorize school personnel to make such arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgment. I further authorize the physician named below to undertake such care of my child, as he/she considers necessary. In the event said physician is not available, I authorize such care and treatment to be performed by a licensed physician or surgeon. I understand that the parent or guardian is responsible for the cost of such emergency care.

Physician Name_____ Phone_____ Pager _____

Emergency Facility and Phone Number _____

Does this student have health insurance? ☐Yes ☐No **Does this student have dental insurance? ☐Yes ☐No**

Name of Insurance or Health Plan Provider:_____ Student's Medical Record Number: _____

If not, I give permission to SCUSD to share this information to help apply for health insurance for my child. ☐*Yes* ☐*No*

The information provided is accurate to the best of my knowledge, and I understand my responsibility.

_____

Legal Name/Signature of Parent/Guardian Registering Student ***Relationship to Student*** ***Date***