

**MILFORD SCHOOL DISTRICT**  
**STUDENT REGISTRATION FORM (MMS and MHS)**

<b>STUDENT INFORMATION</b>		Date of Birth _____	Town of Birth _____
Last Name _____	First _____	Middle _____	Grade _____
Home Address _____		Apt# _____	Gender _____
City _____	State _____	Zip _____	Home Phone _____
Mailing Address (If different than home) _____		Apt# _____	
City _____	State _____	Zip _____	Bus # _____ AM _____ PM
Student Lives with _____		Previous school attended _____	
Primary Parent Contact _____		Phone # _____	
Is this student Hispanic/Latino? (please check ONE): <input type="checkbox"/> Yes, Hispanic/Latino <input type="checkbox"/> No, not Hispanic/Latino			
Student's Race (check as many as apply): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian			
<input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White			

<b>CONTACT INFORMATION</b>	
<b>Parent/Legal Guardian #1</b> _____	Home Phone _____
Address _____	Employer Name _____
_____	Employer Phone _____
Email _____	Cell _____
Relationship to student _____	Receive mailings _____
<b>Parent/Legal Guardian #2</b> _____	Home Phone _____
Address _____	Employer Name _____
_____	Employer Phone _____
Email _____	Cell _____
Relationship to student _____	Receive mailings _____

<b>EMERGENCY CONTACTS</b>	
(Adults other than those listed above who are willing to assume temporary care of your child and will be contacted if we are unable to contact a parent or guardian.)	
<b>1</b>	Full Name _____ Daytime Phone _____
	Relationship _____ <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> work
<b>2</b>	Full Name _____ Daytime Phone _____
	Relationship _____ <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> work
<b>3</b>	Full Name _____ Daytime Phone _____
	Relationship _____ <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> work

Are there any restrictions regarding dismissals, visitations, or information on your child? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain _____
<b>If there are legal restrictions for the school to observe, i.e., custody/guardianship orders or protection orders, the school must be provided with the appropriate legal documentation.</b>

\_\_\_\_\_  
Parent /Guardian signature

\_\_\_\_\_  
Date

Student Name \_\_\_\_\_

Grade \_\_\_\_\_

**MEDICAL HISTORY**

**Does the student HAVE?**

Asthma-----	Yes	No
Seizures-----	Yes	No
Diabetes-----	Yes	No
Hearing problem-----	Yes	No
Vision problem-----	Yes	No

**Does the student USE?**

Inhaler@ school -----	Yes	No
Epi-Pen for allergic reactions--	Yes	No

**May we have permission to give:**

Tylenol (pain or fever) -----	Yes	No
Ibuprofen (pain) -----	Yes	No
Tums (indigestion) -----	Yes	No
Benadryl -----	Yes	No
(emergency allergic reaction only)		

**ALLERGIES**

Bees-----	Yes	No
Environmental-----	Yes	No
Seasonal-----	Yes	No
Food(s) -----	Yes	No
Medication(s)-----	Yes	No

Please list food(s) and/or medication(s), then describe type of reaction(s)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications (please list)**

_____	Home	School
_____	Home	School
_____	Home	School

Should the school nurse be aware of any other medical problems or restrictions? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\*\*\* The State of NH requires parent permission and a doctor's order for students who need an Epi-Pen, inhaler, or prescription medications while in school. Please contact the nurse for parent form(s). \*\*\*

Doctor's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone # \_\_\_\_\_

I am interested in having my child screened by the dental clinic. If checked, a permission form will be sent home in October.

**PERMISSION TO PROVIDE EMERGENCY TREATMENT**

I hereby grant permission to the Milford School District to administer First Aid, Epinephrine (Epi-Pen) if necessary, and secure proper emergency treatment for my child in the event a parent or legal guardian cannot be contacted.

\_\_\_\_\_  
Parent / Guardian signature Date

**PERMISSION TO CONTACT STUDENT'S DOCTOR** to confirm immunization and physical exam during the school year (August to June).

\_\_\_\_\_  
Parent / Guardian signature Date

**"I have confirmed all of the above information concerning my child."**

\_\_\_\_\_  
Parent /Guardian signature Date

\*\*\*\*\*PLEASE NOTIFY THE SCHOOL AT ONCE IF INFORMATION CHANGES\*\*\*\*\*

Student Name \_\_\_\_\_

Grade \_\_\_\_\_

***MILFORD SCHOOL DISTRICT***  
**NOTICE OF RESIDENCY REQUIREMENT**

I understand that in order for my son/daughter to attend school in Milford, he/she must be a legal resident of Milford in accordance with New Hampshire RSA:193:12, or be attending under a valid tuition agreement. Failure to comply with this requirement may result in the school district taking legal action to recover tuition costs for the student attendance. If you are unsure about residency requirements, please contact the SAU office at 673-2202.

I have read the above statement and attest that my son/daughter is a legal resident of Milford or is attending as a tuition student. If attending as a tuition student, the School District may seek compensation from me.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date