OFFICE USE ONLY
School Year _____
YOG _____
ID# _____
Advisor _____
Date of Entry _____

Twinfield Union School

Educating Children for Our Communities and the World

106 Nasmith Brook Road, Plainfield, VT 05667 Phone: 802-426-3213 Fax: 802-426-4085

REGISTRATION/ENROLLMENT FORM
&
Health Questionnaire

PLEASE PRINT

Student's Name: _____ Date of Birth: ___/___/_____ Grade: _____
Last First Middle

Ethnicity (*check all that apply*): ☐American Indian/Alaskan Native ☐Asian ☐African ☐Caucasian ☐Hispanic or Latino ☐Native Hawaiian/Pacific Islander

Sex: ☐Male ☐Female

Town of Residence: ☐ Marshfield ☐ Plainfield ***- OR -*** Attends Through: ☐ School Choice (Act 150) ☐ Tuition
Town of Residence: _____

Names of any siblings attending Twinfield: _____

Previous School Name and Address: _____

Does your child have a current education plan? ☐ IEP ☐ 504 ☐ Other special needs _____

CONTACT INFORMATION: Child resides with/in: ☐Parents ☐Mother ☐Father ☐Guardian ☐Temporary or Shared Housing
(If parents separated or guardians involved, please submit a copy of the custody agreement.)

Name of **first** contact (s): (*where child resides*)_____Relationship to student: _____
911 Address – Street/Road/Town (Exact Location and Description of your home): _____
_____

Mailing Address *(if different from above):* _____

Home phone #: _____Work #: _____ Cell #/other#:_____

Email Address (*please print clearly*) _____

Name of **second** contact: _____ Relationship to student: _____
Mailing Address:_____

Email Address (*please print clearly*) _____
Home phone #: _____Work # : _____ Cell #/other#: _____

NON-CUSTODIAL PARENTAL INFORMATION: *Report cards and other communications will be sent to this parent as well*

_____
First Last Relationship to student

_____
Mailing Address Home Phone # Work/Cell #

DAY CARE INFORMATION: _____
Name of Day Care Address Phone

BUS INFORMATION:
My child will get on at _____ and dropped off at _____
(If there are special arrangements, please attach a separate note.)

EMERGENCY TEMPORARY CARE IF YOU CANNOT BE REACHED:
In the event of an illness or an emergency with this student, attempts will be made to reach the parent/guardian. If we are unable to locate you we need to know the names of two (2) NEARBY relatives, neighbors, or friends who will assume temporary care of this child.

1._____Home phone #_____
Name Relationship Work/cell phone # _____

2._____Home phone #_____
Name Relationship Work/cell phone # _____

HEALTH INFORMATION

This information is REQUIRED for the Vermont State Health Department. Please complete all questions.

Child's Name _____Grade_____

Please circle:

My child HAS / DOES NOT have health insurance
(Information on the availability of Student Insurance Plans is available in the office.)

My child HAS / HAS NOT had a well child/adolescent exam by a medical provider in the past year

My child HAS / HAS NOT had a dental check up exam by a dentist in the past year

My child HAS / DOES NOT have asthma

My child HAS / DOES NOT have an asthma action plan

Name of Doctor _____Dentist _____Eye Doctor_____

Circle all that apply: Glasses Contacts New lenses in the past year Date of last eye exam _____

Medical Issues/Problems _____Dental Issues_____

Any Allergies □ YES □ NO If yes, explain _____

ALL CURRENT MEDICATIONS:

Taken at home: _____Needed at School: _____

I give permission for the school nurse to give and receive health information to/from my child's:

□ Primary Care Physician □Eye Doctor □Dentist □Counselor □Other _____

Signature of Parent/Guardian _____Date _____

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION

PERMISSION TO GIVE: *(please circle)*

TYLENOL IBUPROFEN BENADRYL COUGH DROPS OTHER _____

Signature of Parent/Guardian _____ Date _____

AUTHORIZATION FOR EMERGENCY TRANSPORTATION/TREATMENT:

Name of student:_____

In case of accident or illness, I request the school to contact me. If not able to reach me, I hereby authorize the school personnel to seek emergency medical care, including transportation to the emergency room. I hereby authorize the physician in charge to administer whatever emergency treatment is necessary at my expense.

Signature of Parent/Guardian _____ Date: _____

OPTIONAL: If you are a member of the US Military: (□Active Duty □National Guard □Reserves)

Is there a possibility of deployment in the future that could affect your child(ren)'s learning? □Yes □No