2008-2009 REGISTRATION FORM

Bullis Charter School

102 West Portola Avenue, Los Altos, CA 94022-1210

STUDENT INFORMATION (*PLEASE PRINT AND USE INK.*)

NAME: ____

Last Name First Name Middle Name

PRIMARY ADDRESS: ____

Street City Zip

PRIMARY PHONE #: ( ) ______________________ **MALE** ☐ **FEMALE** ☐

Present Grade: _____ **Applying for Grade:** _____ **Birthdate:** ________________

Current School District: ______________________________

Please note: Information on this form may be shared with the Santa Clara County Office of Education, BCS's chartering agency.

● **PARENT/GUARDIAN INFORMATION:** Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Legal Guardian

Note: *If legal custody of a child is split between two parents, please attach a certified copy of the court order identifying each parent's respective award of physical custody. You are responsible to immediately inform the school of any changes to the court order.*

- **Mother/Guardian Name**: ______________________ Occupation: ________________

  Address *(if different from above)*: ______________________________

  Home Phone *(if different from above)*: ________________ Business Phone: ________________

  Cell/Pager #: ________________ E-mail: ________________

- **Father/Guardian Name**: ______________________ Occupation: ________________

  Address *(if different from above)*: ______________________________

  Home Phone *(if different from above)*: ________________ Business Phone: ________________

  Cell/Pager #: ________________ E-mail: ________________

PREVIOUS SCHOOL(S) (LIST PRE-SCHOOL IF APPLICABLE)

Grades Attended	Date Enrolled	Date Left	School	Public (Y/N)	State	County

● Languages spoken at home: 1. ________________ 2. ________________

● Other children at home:

Name *Grade / School* *Name* *Grade / School* *Name* *Grade / School*

● Are there any Custody, Visitation, or other orders limiting access to this child? ☐ Yes ☐ No

If yes, specify orders: ______________________________

● Please list the names of relatives/friends/neighbors ***IN CLOSE PROXIMITY TO THE SCHOOL***, to whom we may release your child or contact if you cannot be reached. NOTE: In the event of an emergency or disaster, the parent/guardian will be phoned first.

Name *Phone #* *Name* *Phone #*

Name *Phone #* *Name* *Phone #*

Name *Phone #* *Name* *Phone*

OVER....

STUDENT HEALTH HISTORY
CURRENT HEALTH INFORMATION

- *Information obtained from this health history will be included on a confidential health conditions list, if appropriate.*

Does your child have any of the following medical conditions? Please check the appropriate boxes:

- ☐ Current seizures
  If checked, on medication? ☐ Yes ☐ No
- ☐ Current asthma
  If checked: ☐uses inhaler ☐on medication
- ☐ Diabetes
  If checked: Insulin dependent? ☐ Yes ☐ No
- ☐ Bee sting allergy
  If checked, requiring: ☐ Epi-pen ☐ Benadryl
- ☐ Behavior problems
- ☐ Hearing aids
- ☐ Movement limitations
- ☐ Prosthesis
- ☐ Speech problems
- ☐ Recent hospitalizations. If checked, please explain: ____________________
- ☐ Severe allergies requiring medication. If checked, please explain: ____________________
- ☐ Other (please explain): ____________________

- Vision or eye problems: ☐ Yes ☐ No
  If yes, wears glasses:
  - ☐ for board work
  - ☐ for reading
  - ☐ all the time

  Date of last eye exam: ____________________

- Medication: If your child requires medication at school, all medication sent to school must be in the prescription container with a current date and an "Authorization for Administration of Medication" form must be on file (obtain from the school office). Please indication:

Medication: __________ Dsge: ___ Hr(s) given: _____

Medication: __________ Dsge: ___ Hr(s) given: _____

SPECIAL EDUCATION

Does the student have an active IEP? ☐No ☐Yes

If Yes, please attach a copy of the IEP with your application.

	Date Entered	Date of Last IEP Meeting
☐ Mental Retardation (10/MR)		
☐ Hard of Hearing (20/HH)		
☐ Deaf (30/Deaf)		
☐ Specific Learning Disablity, please name: __________(40/SLI)		
☐ Visual Impairment (50/VI)		
☐ Emotional Disturbance (60/ED)		
☐ Orthopedic Impairment (70/OI)		
☐ Other Health Impairment, please specify: __________(80/OHI)		
☐ Speech/Language Impairment (90/SLD)		
☐ Deaf-Blind (100/DB)		
☐ Multiple Disability, please specify which ones: __________(110/MD)		
☐ Autism (120/AUT)		
☐ Traumatic Brain Injury (130/TBI)		

Please identify which school district developed the IEP: ____________________

The undersigned declares that the address of the student given above is the true and correct primary residence of the child within the boundaries of the Bullis Charter School, and that the undersigned will immediately inform the School of any change in address which subsequently occurs. In the case of an emergency due to illness or accident, when the school cannot reach the parent/guardian or designated emergency contact, the school authorities are authorized to use their best judgment in the interest of your child's health. It is understood that treatment will not be withheld if the undersigned cannot be reached. I/we understand that the Bullis Charter School does not provide accident/medical insurance for students, and I/we further understand that all costs related to medical treatment shall be my responsibility and not Bullis Charter School's.

<u>The undersigned declares that the above information is true and correct to the best of his/her knowledge. A signature on this registration form indicates the intent of the parent/guardian to enroll his or her child in the Bulllis Charter School.</u>

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Parent/Guardian signature Date