BROOKS-YATES SCHOOL
1005 South Pickaway Street
Circleville, OH 43113
ANNUAL REGISTRATION

Date: _____

Student's Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

Is there a court custody order pertaining to the child? _____ yes _____ no ***A copy of the custody order is needed on file***

Father/Guardian Name: _____ Home Phone: _____

Home Address: _____ Cell Phone: _____

Work Address: _____ Work Phone: _____

Mother/Guardian Name: _____ Home Phone: _____

Home Address: _____ Cell Phone: _____

Work Address: _____ Work Phone: _____

Please list two people to be contacted in the event of an emergency **if the parent cannot be contacted:**

Name	Name
Street address	Street address
City, State, Zip Code	City, State, Zip Code
Relationship to Child	Relationship to Child
Home phone	Home phone
Cell phone	Cell phone
Work phone	Work Phone

If school is closed early due to weather or emergency, and no one is at home, where in your neighborhood should your child go?

_____

_____

_____

Physician	**Dentist**
Name	Name
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone	Phone

Each year we prepare a roster for each group of children in our program. This roster will not be furnished to any persons other than parents of students enrolled in our program.

I authorize the following to be listed on the parent roster:

	Please circle one	
My child's name	Yes	No
Parents/Guardians name	Yes	No
Phone number	Work Cell Home	No

School staff takes pictures of the students for use in scrapbooks, communication books, on building bulletin boards, the website and social media. I understand if my child's name is included in the photo caption only his/her first name will be used. School staff may video students for staff training and program development specific to my child's needs.

I authorize the following regarding photographing and video recording of my child:

	Please circle one	
My child's photo may be taken	Yes	No
Video tape of my child may be taken	Yes	No

_____

Signature of parent/guardian **Date**

Chronic physical problem(s):
History or Hospitalization:
Diseases this child has had:
Allergies and treatment:
Medications, food supplements, modified diet, or fluoride supplements:

If your child needs medication during school hours you must compete a medication registration form, and have it signed by the child's physician.

List of Person(s) whom this child can be released:

List of Person(s) NOT PERMITTED to pick up this child:	Restraint papers or Divorce decree attached
	Yes No
	Yes No

IMPORTANT: Please attach a copy of your child's immunization records

Exempt from immunizations	**Please circle one**	
Religious conviction	Yes	NO
Other:		

Parent/Guardian signature for immunization exemption: _____ Date:_____ _____