



ALEXANDRIA CITY PUBLIC SCHOOLS
Student Registration Form

Student's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Student Address: Street \_\_\_\_\_ Apt # \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Male: \_\_\_ Female: \_\_\_ Date of Birth: Mo: \_\_\_ Day: \_\_\_ Year: \_\_\_ Country of Birth: \_\_\_\_\_

Is this student Hispanic or Latino? (choose only one)

- No, not Hispanic or Latino
Yes, Hispanic or Latino (person of Cuban, Mexican, Puerto Rican, South American, Central American, or other Spanish culture or origin, regardless of race)

What is the student's race? (choose one or more)

- American Indian/Alaskan
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White (a person having origins in any of the original peoples of Europe, the Middle East or North Africa)

What is the student's primary language? English Spanish Amharic Arabic Other (please specify) \_\_\_\_\_

Student: U.S. Citizen: Yes \_\_\_ No \_\_\_
Parent: Is the City of Alexandria your legal residence? Yes \_\_\_ No \_\_\_
If No, has an exception to policy been approved? Yes \_\_\_ No \_\_\_

Birth Certificate: Yes \_\_\_ No \_\_\_ Birth Certificate #: \_\_\_\_\_

Parent/Guardian #1:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_

Father: \_\_\_ Stepfather: \_\_\_ Legal Guardian: \_\_\_

Mother: \_\_\_ Stepmother: \_\_\_ Foster Parent: \_\_\_

Other (please indicate relationship) : \_\_\_\_\_

Address: Check if address is the same as above

Street \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ E-Mail Address: \_\_\_\_\_

Parent/guardian's primary language? English Spanish Amharic Arabic Other (please specify) \_\_\_\_\_

Parent/Guardian #2:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_

Father: \_\_\_ Stepfather: \_\_\_ Legal Guardian: \_\_\_

Mother: \_\_\_ Stepmother: \_\_\_ Foster Parent: \_\_\_

Other (please indicate relationship) : \_\_\_\_\_

Address: Check if address is the same as above

Street \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ E-Mail Address: \_\_\_\_\_

Parent/guardian's primary language? English Spanish Amharic Arabic Other (please specify) \_\_\_\_\_



Physician's Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

If we are not able to contact you or the physician listed above, do we have your permission to take your child to the emergency room of the nearest hospital, at your expense, and do we further have your authorization for the hospital and its medical staff to provide such treatment as a physician deems necessary for the well-being of your child?

Yes \_\_\_\_\_ No \_\_\_\_\_

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

Date: \_\_\_\_\_

**Other Children in the Family:**

Name	Birth Date	Sex	School
1.			
2.			
3.			
4.			

**Please check if your child has any medical conditions:**

- Allergy                       Asthma                       Autism                       Diabetes                       Heart Disease  
 Hearing Impaired               Seizure Disorder               Visual Impairment (including wears glasses or contacts)  
 Other mental or physical impairment (please specify) \_\_\_\_\_

Does your child have a current IEP for Special Education services or 504 Plan? \_\_\_Yes \_\_\_ No

If yes, has documentation been provided to the school? \_\_\_Yes \_\_\_ No

**Emergency Contact #1 (Other than Parent/Guardian):**

Name: \_\_\_\_\_  
 Address: Street \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Relationship to student: \_\_\_\_\_

**During the year before Kindergarten my child attended (choose 1):**

- Head Start  
 Child and Family Network Center  
 Child Care Center (full day, full year)  
 Name: \_\_\_\_\_  
 Half-Day Program (preschool)  
 Name: \_\_\_\_\_

**Home Based Child Care**

- In My Home Child Care provider  
 In Their Home Child Care Provider  
 Parent/Relative

**Alexandria City Public Schools**

- VPI 4-year old program  
 Early Childhood Special Education  
 Preschoolers Learning Together

**Emergency Contact #2 (Other than Parent/Guardian):**

Name: \_\_\_\_\_  
 Address: Street \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Relationship to student: \_\_\_\_\_

Last School Attended: \_\_\_\_\_ Public or Private (circle one)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If not an Alexandria school, did student EVER attend Alexandria City Public Schools? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please provide the following: School: \_\_\_\_\_ Year \_\_\_\_\_ Grade \_\_\_\_\_

By signing this form I am verifying that the information contained herein is correct.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICE USE ONLY:**

Student ID	School ID	Sch/Res	Att/Permit Code	Address/Transfer Permit Verified	Grade	Entry Code	Entry Date	Office Verification/Signature