Kent Center School
Pupil Registration/ Emergency Form
2020-2021

One form must be filled out for each child.

Home Room _____ Date_____

Student Name (Last, First, Middle): _____

Circle Gender: Male Female Non-Binary Birth Date: _____ Home Phone: (____) _____

Student **ETHNICITY (as required by the State of Connecticut)**
Hispanic or Latino Not Hispanic or Latino

Student **RACE (as required by the State of Connecticut)** Circle **all** that apply
Asian Black/African American White Pacific Islander/Native Hawaiian American Indian/Alaska Native

Street Address: _____

Student Mailing Address: _____

Student lives with: _____Mother _____Father _____other (Name: _____)

Parent #1 Name:_____

Parent #1 Work Phone: (____) _____ Parent #1 Cell phone: (____) _____

Primary Contact Email: _____

Parent # 2 Name: _____

Parent # 2 Work Phone: (____) _____Parent # 2 Cell Phone :(____) _____

Optional 2nd Email: _____

If you cannot contact me at home or work, you may send or release my child to:

1_____ _____ (____) _____
Emergency Contact Name Relationship Phone Number

2_____ _____ (____) _____
Emergency Contact Name Relationship Phone Number

3_____ _____ (____) _____
Emergency Contact Name Relationship Phone Number

Is this child youngest at KCS? ____Yes ___No

Other Siblings at KCS: _____Home Room _____

_____Home Room _____

_____Home Room _____

If you are divorced, separated, remarried, or a single parent, please read on:
The law states that unless we have a court order saying one parent does not have a legal right to see the child or his/her records, we may not refuse to let either parent take the child from school or withhold information regarding school records.
A copy of the court order must be on file in the school office.
Initial here if a court order is on file _____

HEALTH INFORMATION

Student Name:_____Grade:_____Date:_____

Does this student have health insurance? (Please check one)Yes_____No_____

Allergy Concerns: _____

Health/Medical Concerns:_____

Recent immunizations, injuries, surgery:_____

Special Needs:_____

Primary Physician: _____Telephone: ___(____)_____

Primary Dentist: _____Telephone: ___(____)_____

Preferred Hospital_____

Please indicate permission granted (Yes) or denied (No) for the school nurse or trained school personnel To administer the following treatments, as prescribed by the school physician, Dr. Lefebvre.
***Generic forms may be used. *Manufacturer dosage recommendations will be followed.**

A+D ointment for dry skin, chapped lips	Yes	No
Ammonia (After Bite) for bee sting	Yes	No
Bacitracin ointment for lacerations, tick bites, abrasions, or local wounds	Yes	No
Benadryl for allergic reactions	Yes	No
Calamine lotion for itchy rash or insect bites	Yes	No
Cough drops for cough- (provided by parent)	Yes	No
DEET containing bug spray for prolonged seasonal outdoor exposure	Yes	No
Epipen auto-injector, appropriate dose, may be given by trained unlicensed school personnel, in the absence of the school nurse, for treatment of anaphylaxis allergic reaction	Yes	No
Hydrogen Peroxide for wound cleansing	Yes	No
Ibuprofen (Motrin or Advil) for headache, pain, or discomfort	Yes	No
Rubbing alcohol for pierced ear irritation	Yes	No
Sunscreen for prolonged sun exposure (provided by parent)	Yes	No
Throat drops for scratchy throat-(provided by parent)	Yes	No
Tylenol for headache, mild to moderate pain	Yes	No
I give permission for the Primary Physician and Dentist, named above, to communicate with the school nurse and for them to share health information regarding my child .	Yes	No
I give permission for the school nurse to share appropriate medical concerns with my child's bus driver.	Yes	No

Parent/Guardian Signature: _____Date:_____

School Medical Advisor_____Date:_____

Suzanne LeFebvre, MD