



# Student Data / Registration Information



## Milan Area Schools

Please review the Student Information we have on file for your student to be sure it is accurate. Please bring this sheet to registration with any corrections or additions noted. Thank you.

<b>Student Name:</b>		<b>Student ID #:</b>
		<b>CORRECTIONS or REQUESTED INFO.</b>
To the Parent/Guardian of:		
Mailing Address:		
City / State / Zip Code:		
Home Address:		
Home or Primary Phone:		
<b>STUDENT DATA</b>	Student's Gender (F or M):	
	Student's Birthdate:	
	City or Place of Birth:	
	Multiple Birth order:	
	<small>It is federal regulation to report the ethnicity of students. Please indicate one Primary Ethnicity. You can choose up to five secondary ethnicities 1=American Indian/Native American, 2=Asian American, 3=Black/African American, 4=Natural Hawaiian/Other Pacific Islander, 5=White not of Hispanic Descent, 6=Hispanic</small>	
Primary Ethnic Code:		
Grade Level During 2009-2010:		
<b>NEW STUDENT or KINDERGARTEN</b>	Has your student ever attended Milan Area Schools or any program sponsored by the Milan School District? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, What grade or program? _____	
	Name of Last School Attended:	
	City of Last School Attended:	
	State of Last School Attended:	
	Schools of Choice Student Y/N:	
	If School of Choice, Name of Resident District:	
<b>SERVICES</b>	Special Education Services Required? Please circle:	YES / NO
	504 Services Required? Please Circle:	YES / NO
	Student Free / Reduced Lunch Application (please circle):	NEEDED / NOT NEEDED
	Court Placed? Please Circle:	YES / NO
<b>MEDICAL INFORMATION</b>	<b>HEALTH FACTORS:</b> 01=Medical Waiver, 02=Rheumatic, 03=Cardiac, 04=Hemophiliac, 05=Diabetic, 06=Aspirin Allergy, 07=Penicillin Allergy, 08=Iodine Allergy, 09=Multiple Critical Allergies, 10=Epileptic, 11=Contact Lenses, 12=Special Blood Condition, 13=Sulpha Allergy, 14=Vision Impaired, 15=Hearing Impaired, 16=Orthopedic Impairment, 17=INsect Allergy, 18=Serious Disease, 19=Critical Medication Needed, 20=Respiratory Difficulties (not asthma), 21=No Blood Transfusion, 22=Hypoglycemic, 23=Migraine, 24=Arthritis, 25=Asthma, 26=Other (please specify)	
	Health Concerns Y/N (if yes, please identify below):	
	Medical Factor #1	
	Medical Factor #2	
	Medical Factor #3	
	If Other, Please Specify:	
	Doctor Name:	
	Doctor Phone:	
	Hospital:	
	1=UofM, 2=St.Joseph, 3=Saline, 4=Oakwood, 5=Herrick, 6=Mercy Monroe, 7=Wayne County, 8=Other (please specify)	

