CENTRAL CITY PUBLIC SCHOOLS
1711 15TH AVENUE
P O BOX 57
CENTRAL CITY, NEBRASKA 68826-0057
308-946-3055

REQUEST FOR STUDENT RECORDS

DATE____/_____/20____

NAME OF STUDENT________________________________GRADE_________DATE OF BIRTH____________

The student listed above has enrolled in the Central City School District.
Please send all pertinent school records including:

_____Transcript: grades, test scores
_____Health Records: Immunization dates, pertinent health information, medications
_____Official Administration Records: Birth Certificate, Attendance Record
_____Special Education Records: Current IEP, Individual IQ test, psychological evaluations, MDT Report, OT/PT Report
_____Nebraska State Student Record System # (NSSRS)
_____Free and Reduced Lunch Information

Please send information to the school below. Thank you for your cooperation.

Central City Elementary	Central City Middle School	Central City High School
1711 15th Avenue	1711 15th Avenue	1711 15th Avenue
P O Box 57	P O Box 57	P O Box 57
Central City, NE 68826-0057	Central City, NE 68826-0057	Central City, NE 68826-0057
308-946-3057 Office	308-946-3056 Office	308-946-3086 Office
308-946-3149 FAX	308-946-2124 FAX	308-946-2954 FAX
Principal's Signature	Principal's Signature	Principal's Signature
_________________________	_________________________	_________________________

PARENT RELEASE

I hereby give my permission to the school listed below to release the requested information to the Central City School District.

Name of Previous School____
Address, City, State, Zip____
Parent or Guardian Signature____

CCPS 12.2016

CENTRAL CITY PUBLIC SCHOOLS

STUDENT REGISTRATION FORM

SELECT BUILDING: ☐ Elementary ☐ Middle School ☐ High School Today's Date: ________________

PLEASE COMPLETE THE FOLLOWING VITAL INFORMATION

Student Legal Last Name	First Name	Middle Initial	Present Grade	Gender

Social Security Number *	Birthdate	Birthplace - City & State or Country (if other than USA)	Home Phone Check if unlisted ☐

Race/Ethnicity (Check One)

Is the Individual Hispanic/Latino?_____Yes _____No _____Asian _____Black or African American _____American Indian or Alaska Native

_____Native Hawaiian or Other Pacific Islander _____White

Home Language	Date this child first attended a school in the USA(Mo/Yr) _____/_____	City & State of school that child first attended in the USA.

PRIMARY HOUSEHOLD INFORMATION: Name(s) of person(s) **WITH WHOM STUDENT IS LIVING.**

Living With: (Check one) Use page 2 to supply information concerning other parent(s) and/or guardian(s).

______ Both Parents ______Mother Only ______Father Only ______Self ______Agency(Foster)_______Guardian

______ Mother/Stepfather ______Father/Stepmother ______Stepfather/Stepmother ______Other _______________

Where does the student stay at night? ____In a home you rent/own ____Other____________________________

____Temporarily with another family in house/mobile home or apartment ____In a hotel or motel

Title (circle): Mr. Mrs. Miss Ms. Last Name	First Name	Work Place & City	Business Phone	Ext.
			Cellular/Pager:	email address
Title (circle): Mr. Mrs. Miss Ms. Last Name	First Name	Work Place & City	Business Phone	Ext.
			Cellular/Pager:	email address

Parent/Guardian Street Address	City	Zip	County
Parent/Guardian Mailing Address (if different than above)	City	Zip	County

EMERGENCY INFORMATION: List two local persons (other than yourself) usually available during the school day who have agreed to care for and provide transportation for your student if he/she becomes ill or injured and you cannot be reached. We attempt to contact parents first.

Last Name	First Name	Relationship to Student	Daytime Phone ☐ H ☐ C ☐ W	Ext.
Last Name	First Name	Relationship to Student	Daytime Phone ☐ H ☐ C ☐ W	Ext.

Enter the name of your family physician who may be contacted by school staff when parent cannot be reached and medical assistance is indicated. If you have no family doctor, you can state any local physician.

Family Doctor	Phone Number	Ext.
Family Dentist	Phone Number	Ext.

* Disclosure of a student's social security number is voluntary. The number is used as a student identifier. It will be used solely for state and local statistical purposes.

2ND MAILING INFORMATION, if any: Name of Parent(s) and/or Guardian(s) OTHER than those listed under Primary Household Information.

Title (circle): Mr. Mrs. Miss Ms. Last Name, First Name	Address, City, ST, Zip	Relationship to Student	Business Phone	Ext.
			Cellular/Pager:	email address

PARENT NOTIFICATION: According to the Family Educational Rights & Privacy Act (FERPA), both custodial and non-custodial parents have the same access to the child and to educational records concerning their child, UNLESS the school has been provided with a court order or other legally binding document relating to such matters as divorce, separation, or custody that specifically revokes those rights. (34 CFR99.4) The school MUST have a copy of the most recent court order on file; otherwise either parent has access to school records and may also check the child out of school (with proper identification). Your signature and date on this application acknowledges only that you have read this notification.

LIST ALL OTHER CHILDREN LIVING IN PRIMARY HOUSEHOLD THAT ARE UNDER THE AGE OF 20 YEARS

Last Name	First Name	Birthdate	Gender	Grade	Birthplace - City & State
Last Name	First Name	Birthdate	Gender	Grade	Birthplace - City & State
Last Name	First Name	Birthdate	Gender	Grade	Birthplace - City & State
Last Name	First Name	Birthdate	Gender	Grade	Birthplace - City & State
Last Name	First Name	Birthdate	Gender	Grade	Birthplace - City & State
Last Name	First Name	Birthdate	Gender	Grade	Birthplace - City & State

PREVIOUS SCHOOL INFORMATION:

Last School or Daycare Attended	Grade	Address of Former School - City, State, Zip

Has this student ever attended Central City Public Schools? ______Yes ______No
If yes: Name of School Attended__________________________________ Grade(s) Attended ______________________________

Has this student ever been enrolled in Special Education?____Yes ____No Is student currently enrolled in this program?____Yes____No
Has this student ever been enrolled in ELL?____Yes___No Is student currently enrolled in this program?______Yes _____No
Has this student ever been enrolled in a Gifted Program?_____Yes ____No Is student currently enrolled in this program?____Yes_____No
Is this student a ward of the State? _____Yes _____No Is this student a ward of the Court?_____Yes _____No
If the student is a ward, our office needs a copy of state or court ward papers prior to admission.
Temporary guardianship: Our office needs Limited Durable Power of Attorney papers completed.

Name of student's caseworker____Phone Number ___________________________

RESIDENCY VERIFICATION; The residency information provided on this form is true and accurate as of this date. I understand that falsification of an address or the use of any other fraudulent means to achieve an enrollment or assignment shall be cause for revocation of the student's enrollment and assignment to the school serving the home attendance area.

Signature of Parent/Guardian ____ Date ________________________

CENTRAL CITY PUBLIC SCHOOLS

Home Language Survey

Student Name: ______________________ Birth Date: ___________________

Parent/Guardian Name: ____

School: ______________________________

Grade: _________ Gender: ___Male ___ Female

1) What language did the student first learn to speak?

2) What language is spoken most often by the student?

3) What language does the student most frequently use at home?

__________________________________ _________________

Parent/Guardian Signature Date

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COUNSELOR INFORMATION REQUEST

DATE____/_____/20____

NAME OF STUDENT_________________________________**GRADE**_________

To help the school counseling staff better understand your student's academic and personal needs, please complete the following questions. Thank you for your cooperation.

Please rate the following:

Student's READING Ability:	_____Above Average	_____Average	_____Below Average
Student's MATH Ability:	_____Above Average	_____Average	_____Below Average

What kind of GRADES did your student earn last year?

_____A's _____A's & B's _____B's _____B's & C's _____C's
_____C's & D's _____D's _____D's & F's _____F's

Has your student received any extra assistance from any of the following services? If yes, please explain in the area provided.
SPECIAL EDUCATION OR RESOURCE HELP: _____No _____Yes (Please list below the type of services received and the student's disability)

____

____

Speech Therapy: _____No _____Yes (Please list below the type of services received)

____

Physical Therapy: _____No _____Yes (Please list below the type of services received)

____

Counseling: _____No _____Yes (Please list below the type of services received)

____

Has your student ever been held back a grade? _____No _____Yes (If yes, what grade:___________)

Has your student experienced any extreme trauma or crisis? (Accident, Injury, Illness, Family Crisis, etc.)
_____No _____Yes (Please explain) ____

____

Are there any other concerns that the counselors can help with? __________________________________

____

____

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ANNUAL STUDENT HEALTH UPDATE REQUEST

(THIS FORM IS REQUIRED FOR ALL STUDENTS IN THE DISTRICT)

SCHOOL YEAR______________FULL NAME OF STUDENT_____________________________________GRADE_________

Last Physical Exam Date: _______Last Dental Exam Date: _______Vision Specialist: _____________Last Vision Exam Date:_______

Does your student have any hearing concerns: _____No _____Yes, please explain: ________________________________

Has your student ever had ear tubes? _____No _____Yes (List year of Insertion) __________

Does your student have any vision concerns? _____ No _____Yes, please explain: ________________________________

Has your student ever worn contacts or glasses?_____No _____Yes, please explain: ________________________________

Allergies: _____No _____Yes (Please list)____

NOTE: ANY life threatening bee sting allergies or food allergies require a written note, from your student's physician, with specific instructions for school personnel.

Does your student have any of the following: (Circle Y for Yes and N for No)

Asthma	Y / N	Emotional Concerns	Y / N	Hepatitis	Y / N
ADHD/ADD	Y / N	Epilepsy/Seizure	Y / N	Orthopedic Concerns	Y / N
Cerebral Palsy	Y / N	Heart Conditions	Y / N	Other	Y / N
Diabetes	Y / N				

If yes, please provide additional information about the current condition and management below.)

____

Has your student had a recent injury or illness that might limit them in school? _____No _____Yes, please explain:

____

Recent immunizations? _____No _____Yes, please list: ____

EMERGENCY INFORMATION: List two local persons (other than yourself) usually available during the school day

____ ____

Name Phone Name Phone

PLEASE LIST ANY MEDICATION YOUR STUDENT WILL BE TAKING:

AT SCHOOL: ____

AT HOME: ____

NOTE: YOU ARE REQUIRED TO COMPLETE A MEDICATION PERMISSION FORM FOR YOUR STUDENT TO TAKE ANY MEDICATION AT SCHOOL. THIS WILL BE COMPLETED FOR ALL NEW MEDICATIONS AND EACH TIME THERE IS A CHANGE IN DOSAGE, TIME, OR ADMINISTRATION. MEDICATION MUST BE BROUGHT IN THE ORIGINAL LABELED CONTAINER.

May the School Nurse or Her Designee Provide Acetaminophen to your Student? _____NO _____YES

May the School Nurse or Her Designee Provide Ibuprofen to your Student? _____NO _____YES

NOTE: Your signature below does the following:

- **Gives the School Nurse or her designee permission to release health information to school personnel if needed for education and/or safety reasons.**
- **Gives School Personnel permission to follow the attack on Asthma Protocol in the Central City Public Schools Student Handbook.**

SIGNATURE OF PARENT OR GUARDIAN: ___________________________________ DATE: ______________________