



Superior Elementary School
Superior, Nebraska

STUDENT REGISTRATION FORM
CONFIDENTIAL

Entry Date *(office use)*

Student Information

Last Name First Name Middle Name

Name child goes by if DIFFERENT from given or legal name Social Security No.

Sex M/F Date of Birth Birth City/State/County

Ethnic Origin (CIRCLE ONE): HISPANIC/LATINO AMERICAN INDIAN/ALASKA NATIVE ASIAN
BLACK/AFRICAN AMERICAN HAWAIIAN/PACIFIC ISLANDER WHITE

Primary Language Spoken Secondary Language Spoken Citizenship Status

Kansas Resident? Yes ___ No ___ Mother Deceased ___ Parents Divorced ___

Grade Will student ride rural bus? Yes ___ No ___ Father Deceased ___ Parents Separated ___

Permanent Address Phone Number

Residing With How related to applicant? Has Custody? Yes ___ No ___

Parent/Guardian Information

Father:

Name Phone Number

Address (Street, City, State, Zip) Email Address

Education Occupation Employer/Phone No.

Mother:

Name Phone Number

Address (Street, City, State, Zip) Email Address

Education Occupation Employer/Phone No.

**Guardian:
(If Applicable)**

Name Phone Number

Address (Street, City, State, Zip) Email Address

Education Occupation Employer/Phone No.

Siblings

Last Name First Name Date of Birth
Lives with family? Yes ____ No ____ Sex M/F _____

Last Name First Name Date of Birth
Lives with family? Yes ____ No ____ Sex M/F _____

Last Name First Name Date of Birth
Lives with family? Yes ____ No ____ Sex M/F _____

Last Name First Name Date of Birth
Lives with family? Yes ____ No ____ Sex M/F _____

Others in Home

First and Last Name Relationship Date of Birth

First and Last Name Relationship Date of Birth

First and Last Name Relationship Date of Birth

Educational

Does student have an IEP? (Receive Special Education Services?) Yes ____ No ____

Has your child previously attended Preschool? Yes ____ No ____ If yes, name: _____

What other schools has your child attended? _____

Medical

Does the parent or student have any health concerns? Yes ____ No ____ If yes, specify: _____
(ie. Severe allergy, asthma, diabetes, etc.)

Does your child wear glasses? Yes ____ No ____

Emergency Contact

First and Last Name Address Phone

First and Last Name Address Phone

Parent Signature: _____ Date _____

PALLS Enrollment

Developmental/Medical History

Were there any complications during pregnancy or birth? (e.g. premature birth, preeclampsia, toxemia, etc.) _____

Has the doctor expressed concerns at any Well Child Checks with your child not meeting developmental milestones? _____

Do you have any concerns about the following and if so please explain:

Yes _____ No _____ **Language Development** _____

Yes _____ No _____ **Speech Development** _____

Yes _____ No _____ **Cognitive Thinking Skills** _____

Yes _____ No _____ **Gross/Fine Motor Skills** _____

Yes _____ No _____ **Vision** (*squinting, headaches, holding books or toys close, sitting close to the TV, family history, itchy or watery eyes, tilts or turns to side, excessive blinking*) _____

Yes _____ No _____ **Hearing** (*Doesn't turn toward sounds, turns the TV or music louder than others, seems to favor one ear, can't hear if you whisper, talks loudly does not seem to speak as well as other children the same age, etc.*) _____

Yes _____ No _____ **History of Ear Infections** _____

Yes _____ No _____ **Overall Health** _____

Current Medications _____

Developmental/Medical History

Family History

Are there any immediate family members who have had:

Speech Problems _____

Hearing Problems _____

Vision Problems _____

Mental Health Concerns _____

Learning Problems _____

Other Health Concerns _____