DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT REGISTRATION

INSTRUCTIONS
1. Completed by Sponsor
2. Print (Ink) or type all entries.
3. Leave shaded areas blank.
4. See supplemental sheet for assistance.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 2164, 20 USC 921

PRINCIPAL PURPOSE(S): Required for enrollment of dependents into DoDEA Schools. Provides record of student and sponsor demographic data used in the administration of school programs. Provides emergency contact, pertinent medical and other vital information.

ROUTINE USE(S): Data is collected and entered into the automated School Information Management System for use by DoDEA personnel in providing educational and management programs. Release of student information to non-DoDEA personnel is restricted to U.S. Government personnel and other authorized individuals as approved by DoDEA. Sponsor information may be released to other schools, colleges, and prospective employers as part of the individual student record.

DISCLOSURE: Voluntary. Disclosure of the Social Security Number will expedite the registration process.

SECTION I – STUDENT INFORMATION

1a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone		g. Student Grade
h. Birth Date (MMMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

2a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone		g. Student Grade
h. Birth Date (MMMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

3a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone		g. Student Grade
h. Birth Date (MMMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

SECTION II – SPONSOR INFORMATION

4. Sponsor's Name (Last, First, Middle Initial)		6. Pay/Civ Grade	7. Title / Rank
8. Organization	9. Location of Unit	10. Duty Phone	11. Rotation / ETS Date

12. Spouse's Name (Last, First, Middle Initial)	13. Spouse's Title	14. Spouse's Employer	15. Spouse's Duty Ph.

16. Mailing Address (e.g. APO/FPO) (If different from Physical)	17. Physical Quarters Address (Street, City, State, Zip Code)

18. Sponsor Cell Phone	19. Spouse Cell Phone	20. Email Address
21. Pager Number	22. Reserved	23. Local Use

SECTION III – LOCAL EMERGENCY CONTACT INFORMATION

24a. Emergency Contact Name (Not Sponsor or Spouse)	24b. Contact Duty Phone	24c. Contact Home Phone
24d. Emergency Contact Address (During Day)	24e. Doctor's Name (If not Military Clinic)	24f. Doctor's Phone Number
25a. Emergency Contact 2 Name (Optional)	25b. Contact 2 Duty Phone (Optional)	25c. Contact 2 Home Phone
25d. Emergency Contact 2 Address (Optional)	25e. Local Use	

SECTION IV – PERMANENT STATESIDE / EMERGENCY CONTACT INFORMATION

26a. Contact Name	26b. Contact Home Phone
26c. Contact Address	26d. Relationship to Sponsor

SECTION V – CONSENT and SCHOOL USE INFORMATION

I understand that I have the right to review my child(ren)'s records and that a copy of the school and health records will be released to the next school (exclusive of colleges and universities) he/she/they attend(s) without further approval.

I give permission for my child(ren) to receive first aid at school and any emergency treatment considered necessary with the following exceptions noted below.

I verify the information is correct or has been corrected.

27. Exceptions (If none, enter NONE)

34. First Day Student Starts School (MMMDDYYYY)	35. DoDAAC HE4438
36. School Name ROBINSON BARRACKS ELEMENTARY/MIDDLE SCHOOL	
37. Orders on File / Verified	Y N
38. Birth Date Verified	Y N
39. Reserved	Y N

28. Signature of Sponsor	29. Date (MMMDDYYYY)	40. Registrar's Initials	41. Date (MMMDDYYYY)
30. Reserved	31. Reserved	42. Reserved	
32. Local Use	33. Local Use	43. Local Use	

Department of Defense Education Activity
Questionnaire for Race/Ethnicity and Home Language

Completion of this form is required for enrollment in DoD schools. The data collected is maintained for "Statistical Use Only" and is protected in accordance with the Privacy Act (93-579), OMB Circular A-108, and DoD Directive 5400.11. Unauthorized disclosure of this information constitutes a violation of the Privacy Act and may result in a fine up to $ 5000.

Race/Ethnicity questions comply with OMB Standards for Maintaining, Collecting, and Presenting Data for Race and Ethnicity, dated 30 Oct 97

STUDENT NAME: _____ **DATE:** _____

PLEASE ANSWER ALL SECTIONS

ETHNICITY (Mark one)

_____ **Hispanic or Latino.** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

_____ **NOT Hispanic or Latino.**

RACE (Mark one or more)

_____ **American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

_____ **Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

_____ **Black or African American.** A person having origins in any of the black racial groups of Africa.

_____ **White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

_____ **Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

HOME LANGUAGE (Yes or No)

1. Does an adult in the household speak a language other than English at home?

_____ **Yes** _____ **No**

2. Does the child you are registering speak a language other than English at home?

_____ **Yes** _____ **No**

If the answer to either question number 1 or number 2 is "yes," please complete the Home language Questionnaire.

ESL Home Language Questionnaire (cont.)

If based on the results of this questionnaire it is necessary to conduct an evaluation, I understand and give my permission for:

1. My child to be evaluated using a standardized language proficiency test and/or academic achievement test to determine whether he/she is eligible for English as a Second Language (ESL) services. Additional information may be collected from my child's teacher(s) and his/her school records.

AND

2. Annual Spring testing to measure my child's academic and English language progress if eligible for services.

I understand that the ESL Teacher will share the results of the assessments with me when testing is completed.

_____ _____

Parent Signature Date

To be completed by ESL Teacher:

Recommendation: ☐ Proficiency Testing ☐ Records Review ☐ No ESL Services Required

Signature of ESL Teacher: _____ Date: _____

Distribution: Original to Student's Cumulative File, Copy to ESL Teacher

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY

ESL Home Language Questionnaire

Privacy Act Notice: Authority to Collect Information: 20 U.S.C. 927(c) and 10 U.S.C. 2164(f), as amended; E.O 9387; the Privacy Act of 1974, as amended, 5 U.S.C. 552a. Principal Purpose: The information will be used within the DoD to determine the services to be provided to a student to assist the child to receive a free appropriate public education. Disclosure to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student services. DoDEA may disclose information requested in this form to other DoD activities and contracted service providers who require the information to deliver educational services to the child and for valid medical, law enforcement or security purposes, or for use in litigation concerning the delivery of student. Routine Uses: Disclosure of information contained in this form is authorized outside the DoD in accordance with the "Blanket Routine Uses" described at the beginning of the Office of the Secretary of Defense's compilation of systems of records notices, published at http://www.defenselink.mil/privacy/notice/osd.

THIS FORM IS COMPLETED AT THE TIME OF STUDENT ENROLLMENT

Child's Name: _____ *Date:* _____

Grade:_____ **Date of Birth:**_____ **Age:** _____

1. What language is commonly spoken in your home?
   ☐ English ☐ Another Language (Please specify): _____
2. Does the child you are registering speak a language other than English? (Excluding foreign languages studied in school.)
   ☐ No ☐ Yes If yes: What language is spoken? _____
3. What language did your child use when he/she first began to talk?
   ☐ English ☐ Another Language (Please specify) _____
4. Has your child attended English speaking schools?
   ☐ No ☐ Yes If yes: How many years? _____
5. What language does your child read and/or write?
   ☐ English ☐ Another Language (Please specify) _____
6. What language do you most often use when speaking with your child?
   ☐ English ☐ Another Language (Please specify) _____
7. What language does your child use most often when speaking to you?
   ☐ English ☐ Another Language (Please specify) _____
8. If your child is cared for by another person on a regular basis, what language is most often used?
   ☐ English ☐ Another Language (Please specify) _____
9. Do you as a parent need to communicate with the school in a language other than English?
   ☐ No ☐ Yes If yes, in what language? _____

Continued on the next page

STUTTGART COMMUNITY ELEMENTARY SCHOOLS
SPECIAL NEEDS PROGRAMS

Many programs are available for children with special needs at our school. If your child has special needs, please indicate his/her needs below.

STUDENT'S NAME: _____ GRADE:_____ AGE: _____ SEX: _____

1. _____ To the best of my knowledge, my child does not need any special program outside the regular classroom. **(Go directly to bottom, sign and date)**

2. **My child needs/has participated in the following programs:**

_____ Enrichment Program (Talented and Gifted)

_____ Special Education (Learning Development, Resource Room, Learning Improvement Specialist, Learning Impaired, etc.)

_____ Compensatory Education

_____ Speech and/or Language Development

_____ Reading Improvement Specialist (Remedial Reading)

_____ Medical Services (Occupational Therapy, Physical Therapy, Handicapped Access, Hearing Impaired, Visually Impaired, etc.)

_____ Counseling Services

_____ English as a Second Language

_____ Other

3. **If your child needs one of the programs listed above, please complete the section below.**

_____ My child has an Individualized Education Program (IEP) from the previous school.

_____ I have records from the previous school indicating my child was in a special program.

_____ My child was in a special program but I do not have any records.

_____ _____

Parent/Guardian Signature Date

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY STUDENT REGISTRATION

FORM 700 – Consents and Authorizations

Effective SY ____/____

INSTRUCTIONS 1. Completed by Sponsor 2. Print (Ink) or type all entries.

THIS FORM IS APPLICABLE FOR THE DURATION OF YOUR CHILD'S ATTENDANCE AT THE CURRENT SCHOOL YEAR AND WILL REMAIN PERMANENTLY IN THE STUDENT'S FILE. YOU MAY REVIEW AND UPDATE THIS FORM AT ANY TIME.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 2164 and 20 U.S.C. 921-932.
PRINCIPAL PURPOSE: To obtain information necessary to enroll students, administer school operations, and protect student health and welfare in DoD operated dependent educational programs. Completed forms are covered by the DoDEA Dependent Children's School Program Files SORN located at http://privacy.defense.gov/notices/DODEA26.shtml.
ROUTINES USE(STo Federal, State and local government officials to protech health and safety in the event of emergencies. The DoD Blanket Routine Uses found at http://privacy.defense.gov/blanket_uses.shtml also apply to this collection
DISCLOSURE: Voluntary, however, failure to disclose the information collected on this form may delay and/or prevent the enrollment of a child and/or the delivery of educational and emergency services.

1. Last Name	2. First Name	3. Student ID

SPONSOR OR GUARDIAN DESIGNATIONS

1. Field Trips: I permit the student(s) that I am registering with this form to participate in authorized DoDEA school field trips as initiated below: **(Mark the appropriate box)**

☐ All scheduled authorized field trips ☐ **Individual field trip by field trip**

2. Media Release: I give permission for my student(s) name and/or image to be used in various media including newsletters, DoDEA web sites (images only), DODEA print and video productions, military community publications, military affiliated publications (Stars & Stripes), military affiliated electronic media (AFN/AFRTS), and public media (local, host nation, U.S. national newspapers, magazines, television). **(Mark the appropriate box)**

☐ Authorize release ☐ Decline release

3. Internet Agreement: I understand that the student(s) I am registering will receive instruction in the appropriate use of DoDEA information technology resources; that in order to use DoDEA resources they must read, understand, and agree to abide by the *Appropriate Use of DoDEA Information Technology Resources – Terms and Conditions for DoDEA Students.* If they violate the Terms and Conditions, I understand they may lose all access privileges on the DoDEA network, and, furthermore, may be subject to school disciplinary and/or appropriate legal actions. **(Mark box indicating agreement)**

☐ Sponsor or Guardian Agreement

4. **11th & 12th grade students only:** I authorize the release of my students' information to military recruiters. **(Mark the appropriate box)**

☐ Authorize release ☐ Decline release

I verify the information is correct or has been corrected.	DATE: (MM/DD/YYYY)
Signature of Sponsor _____	_____

Please complete
ıol to request a
ɔlan, seizure action

DEPARTMENT OF DEFENSE
DEPENDENTS SCHOOLS
Robinson Barracks Elementary/ Middle School

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION
PART I

Name_____
(Student name)

I authorize Robinson Barracks EMS to release the following medical information to:

☐ Child and Youth Services, ☐ USA MEDDAC Stuttgart, and /or ☐ _____

Please initial appropriate box:

_____Physical Form
_____Medication Permission Form
_____Immunization Information
_____Epi-Pen Care Plan (if applicable)
_____Asthma Care Plan (if applicable)
_____Diabetic Care Plan (if applicable)
_____Seizure Action Plan (if applicable)

This release is effective for three year(s) from the date of execution; however I may revoke it at any time by providing notice in writing to the above named party.

_____ _____
Parent/Legal Guardian of Patient Date

Permission for Health Screenings
PART II

I give permission for my child to receive the following health screenings in the health office at the above noted Heidelberg School:

- **Hearing screening**
- **Vision screening**
- **Dental screening (as indicated)**
- **Scoliosis screening (curvature of the spine)**
- **Blood pressure (as indicated)**

The screenings help identify possible health problems but <u>should not replace</u> annual medical examinations with a physician.

_____ _____
Parent/Sponsor signature **Date**

☐ **I refuse the above Health Screenings.** _____ _____
Parent/Sponsor signature **Date**

Robinson Barracks Elementary/ Middle School
School Year 2012-2013 Student Grade_____

MEDICAL POWER OF ATTORNEY

In the event that my dependent (NAME)_____DOB_____,
is injured or becomes ill, necessitating immediate medical examination or care, while under the supervision of or while participating in, any activities sponsored by a Heidelberg School, I authorize and release to any agent or employee of Heidelberg Schools to take my dependent to any U.S. military facility or any civilian hospital if deemed necessary by the above referenced individual.

I understand that the above named personnel of Robinson Barracks Schools will use all diligent and reasonable efforts to contact my spouse or me. If Robinson Barracks School personnel of a or the U.S. treatment facility cannot contact either my spouse nor me after reasonable attempts, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger to life or limb of my dependent. I further authorize non-emergency care and necessary treatment such as suturing superficial lacerations; treating colds, minor allergies, and minor gastro-intestinal upsets; splinting sprains; casting uncomplicated fractures; or other similar treatments.

MEDICAL INFORMATION ABOUT THE ABOVE NAMED DEPENDENT (to be completed by parent/guardian) for the purpose of sharing information with teachers and health care personnel on a need- to-know basis).

My dependent has the following medical problem (s) (such as glasses, diabetes, seizures, asthma, heart, ADHD, or kidney disease):
_____

My dependent is allergic to the following: _____
-Inhalers and Epi-PEN's must have orders from MD

My dependent takes the following medications on a regular and/or "as needed" basis (list name, amount, and purpose of each):
_____

My dependent will be taking medication at school [] NO []YES List medications_____
_____

NOTE: Medication permission form MUST be filled out and signed by prescribing medical doctor and parent annually

I will provide the required medication permission form/action plan for school medications: Yes [] No [] N/A []

PARENT/ EMERGENCY CONTACT INFORMATION (to be completed by parent)
Sponsor's name: _____ Home phone #: _____
Sponsor's unit: _____ Rank: _____
Sponsor's Work Phone #_____ Cell phone #: _____
Sponsor's home address: _____
Sponsor's mailing address:_____
Spouse's name: _____Work phone #: _____
Cell phone #2: _____
Insurance Carrier: [] TRICARE [] Other_____ **Civilian "Pay Patient"?** _____Yes _____ No

Sponsor's Social Security Number-Last 4_____

EMERGENCY CONTACT INFORMATION: To use in case of emergency if parents/guardians are unavailable:

Contact Name (**other than spouse**): _____ Home phone #_____
Cell #_____ Work Phone #_____

Additional comments: _____
I AGREE TO NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES IN THE ABOVE INFORMATION.

Signature of Parent/Guardian_____ Date _____

PRIVACY ACT NOTICE: AUTHORITY: Title V, Sec. 301. PRINCIPAL PURPOSE: To refer to emergency medical facilities in parents'/guardians' absence. ROUTINE USES: (a) To obtain emergency medical care when parents cannot be reached; (b) To provide emergency contact names; (c) To supply health and medical information about student. This form is used by DoDEA employees and trained medical personnel in emergency. Social Security number of sponsor is required by military medical facilities in case of emergency referral. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NONDISCLOSURE: Mandatory. School personnel will not be able to provide emergency care and health services in parents' absence.

REV 3/12

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT HEALTH HISTORY

Explain any of the above here or attach additional pages.

Identify any special health care procedures that your child may require during the school day:

Identify any condition that warrants a restriction of student activity, specify the nature and duration of the limitation and any other information that would help the school assist your child:

Identify any condition that warrants daily and/or emergency administration of medicine for your child and list those medications:

Parent/Sponsor's Signature:	**Primary phone #:**	**Date:**

Grade: _____ SY 12-13

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT HEALTH HISTORY

PRIVACY ACT STATEMENT:

AUTHORITY: 10 U.S.C. sections 2164 and 20 U.S.C. sections 921-932.
PRINCIPAL PURPOSE: To obtain health information about a student enrolling in Department of Defense Education Activity (DoDEA) schools and programs to protect and enhance student health and to promote a safe school environment
ROUTINE USES: DoDEA may release information without prior consent within the DoD when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a(b)(1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a(b)(2-12), and the "Blanket Routine Uses," published at http://www.defenselink.mil/privacy/notice/osd. Examples of release may include for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.
DISCLOSURE: Disclosure to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student services.

NAME *(Last, First, Middle Initial)*

Check: ☐ Female ☐ Male

Date of Birth: ____/____/____ (mm / dd / yyyy)

MEDICAL HISTORY: CHECK (✓) ALL THAT APPLY AND EXPLAIN BELOW OR ATTACH ADDITIONAL PAGE(S).

VISION
- ☐ Wears glasses for reading
- ☐ Wears glasses full time
- ☐ Wears contacts
- ☐ Color deficiency
- ☐ Other

HEARING
- ☐ Frequent ear infections
- ☐ Ear tubes
  Insertion date:
  Are tubes currently in place:
  Right? YES ☐ NO ☐
  Left? YES ☐ NO ☐
- ☐ Hearing loss: Right ☐ Left ☐
- ☐ Other

ENDOCRINE
- ☐ Diabetes
- ☐ Other

DERMATOLOGY
- ☐ Eczema
- ☐ Other

GENITOURINARY
- ☐ Bladder control problems
- ☐ Urinary track infections
- ☐ Other

RESPIRATORY
- ☐ Bronchitis
- ☐ Cystic fibrosis
- ☐ Sinusitis
- ☐ Other

CARDIOVASCULAR
- ☐ Sickle cell disorder
- ☐ Heart murmur
- ☐ Hemophilia/Other Bleeding disorders
- ☐ Rheumatoid heart disease
- ☐ Other

MUSCULOSKELETAL
- ☐ Muscular Dystrophy
- ☐ Scoliosis
- ☐ Other

GASTROINTESTINAL
- ☐ Hernia
- ☐ Other

DENTAL
- ☐ Braces
- ☐ Other

ASTHMA
Date of Diagnosis:

Inhaler needed:
@ school * YES ☐ NO ☐
@ home YES ☐ NO ☐

PSYCHIATRY
- ☐ Anorexia
- ☐ Bulimia
- ☐ Autism
- ☐ ADD/ADHD
- ☐ Depression
- ☐ Substance abuse history
- ☐ Suicidal
- ☐ Other

NEUROLOGICAL
- ☐ Cerebral Palsy
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Spina Bifida
- ☐ Seizures
- ☐ Sleep disorder
- ☐ Other

ALLERGIES (A SHSG Form H-3-7 should be completed.)
- ☐ Bee sting
- ☐ Wasp sting
- ☐ Other insects
- ☐ Seasonal
- ☐ Environmental
- ☐ Food
- ☐ Lactose intolerance (The school will need a letter from the doctor stating that the student is lactose intolerant.)

PROCEDURES: (A SHSG Form H-4-9 should be completed.)
- ☐ My child will/may require special health care procedures during the school day. (See page 2.)

RESTRICTIONS
- ☐ My child has a condition that warrants restriction of activities during school hours. (See page 2)
- ☐ My child takes daily medication at home.
- ☐ My child will need medications during school hours. (* See page 2.)
- ☐ My child may need emergency medications during school hours. (* See page 2.)

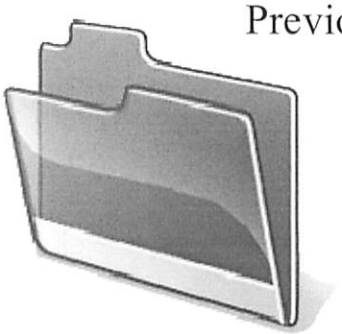
* MEDICATIONS DURING SCHOOL HOURS: SHSG H-3-2, 3-3 and/or 3-8 forms must be signed by the physician and a parent; and must accompany prescribed medications that are to be given during school hours. The medication will be in the original container properly labeled by the physician or pharmacy. All medications will remain at school for the duration of the prescription.

Robinson Barracks Elementary/Middle School
Unit 30401
APO AE 09107
DSN: 420-7112/7363
CIV: 001-49-711-819-7112/7363
FAX: 001-49-711-857-473

REQUEST FOR CUMULATIVE RECORD

_____

Student's Last Name First Middle Date of Birth



Previous School Address: Grade last Attended:_____

_____

_____

_____

This student is now enrolled at Robinson Barracks Elementary/Middle School, Department of Defense Dependent Schools-Heidelberg District. Please forward his/her Cumulative Record to include.

. Grades to date of withdrawal and /or final or most recent report card
. Academic records and test scores
. Attendance
. Health/Medical records
. Special education data (Including IEP)
. Legal/psychological/social reports
. Any other information pertaining to this student

Please forward all records to the following address:
Robinson barracks Elementary/Middle School
ATTN: REGISTRAR
Unit 30401
APO AE 09107

I authorize the release of records for the above mentioned student.

_____
Michelle Coltson
Registrar

_____
Signature of Parent/Guardian