201 South Ukudo St. Dededo, Guam 96929 / (671)989-3789/99 / admin@ilearnguam.org

NEW STUDENT

REGISTRATION FORM

DATE:	SCHOOL YEAR: 20___-20___
STUDENT NAME: *(Last, First, Middle Initial)*	ENTERING GRADE:

Important:

Please follow the instructions carefully, Incomplete documents will be returned

HIGHLIGHTED ARE TO BE SUBMITTED ALONG WITH THE REGISTRATION:	*OFFICE USE ONLY* Date:	Received By:
Registration Form *(for Kinder: must be 5yo by Aug 31st, potty trained, no pull-ups)*	*We are Not accepting registration via email	
COPY of Birth Certificate and Passport		
Report Card *(Grades K-5)*		
School Records / IEP / Withdrawal from Previous School		
Student Medical Information Form		
Updated iLACS Student Physical Examination Form	*PE forms requires the physician or clinic stamp	
Updated Immunization Record Updated PPD or DPHSS clearance, if Positive		
If applicable: Notarized Legal Guardianship Document or Notarized Power of Attorney		

OFFICE USE ONLY Date Received:	*OFFICE USE ONLY* Received by:

iLearn ACADEMY CHARTER SCHOOL

STUDENT'S INFORMATION

Name (Last, First, Middle Initial): _____

Date of Birth: _____ Age: _____ Gender: _____ Grade: _____

Social Security#: _____ Ethnicity: _____

Home Phone#: _____ Previous School Attended: _____

Village Residing: _____ □US Citizen □Permanent Residence □CNMI/FSM

HOME Address: _____

FIRST PARENT STUDENT RESIDES WITH **RELATION TO STUDENT:** _____

Name (Last, First, Middle Initial): _____

Date of Birth: _____ Marital Status: _____

Home Phone# (if same, skip): _____ Cell Phone#: _____

HOME Address (if same, skip): _____

Email Address: _____

Occupation: _____ Employer: _____ Work Phone#: _____

SECOND PARENT STUDENT RESIDES WITH **RELATION TO STUDENT:** _____

Name (Last, First, Middle Initial): _____

Date of Birth: _____ Marital Status: _____

Home Phone# (if same, skip): _____ Cell Phone#: _____

HOME Address (if same, skip): _____

Email Address: _____

Occupation: _____ Employer: _____ Work Phone#: _____

LEGAL GUARDIAN STUDENT RESIDES WITH **RELATION TO STUDENT:** _____

PLEASE READ: Please provide a Notarized Legal Guardianship Document or Notarized Power of Attorney if student is not residing with natural parents

Name (Last, First, Middle Initial): _____

Date of Birth: _____ Marital Status: _____

Home Phone# (if same, skip): _____ Cell Phone#: _____

HOME Address (if same, skip): _____

Email Address: _____

Occupation: _____ Employer: _____ Work Phone#: _____

Does student have a sibling currently attending iLearn? If so, please advise:

1. Siblings Full Name: _____
2. Siblings Full Name: _____
3. Siblings Full Name: _____

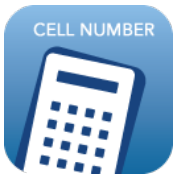
EMERGENCY CONTACT PAGE

Student Name: _____

EMERGENCY CONTACT (other than parents):

Name (Last, First, Middle Initial): _____

Relation to Student: _____



EMERGENCY CONTACT / AUTHORIZED TO PICK UP YOUR CHILD FROM SCHOOL (other than parents):

NAME	RELATION	DAYTIME PHONE #		
1.		H:	C:	W:
2.		H:	C:	W:
3.		H:	C:	W:

Please indicate if your child has received any special education services (circle): Yes / No

If yes, please explain:

LIABILITY AGREEMENT

Student's Name: _____

I understand that classes end at 2:30pm and I am responsible for picking up my child no later than 3:00pm.

iLearn Academy Charter School, its employees, Board Members, or agents, are Not held responsible for my child's safety and wellbeing, should my child be on campus after 3:00pm.

I acknowledge that:

- Initial 1st Offense: Warning
- Initial 2nd Offense: Meet with the Principal
- Initial 3rd Offense: Withdrawal

Parent/Guardian's Signature: _____

Print Name and Date: _____

PHOTO RELEASE/VIDEO RELEASE

Throughout the year, iLearn Academy Charter School catalogs events through pictures and videos. These pictures and videos are used in various printed and electronic mediums such as newspaper ads, brochures, websites, and DVDs. Please indicate whether or not iLearn has permission to use any pictures or videos of your child. Agreement would not be restricted to the above mentioned mediums.

Please initial one:

_____ Yes, I give iLearn permission to use any pictures of my child in the above stated media.

_____ No, I do not want my child's picture to be used in the above stated media.

STUDENT MEDICAL INFORMATION

STUDENT NAME: _____

MEDICAL HISTORY:

Does your child have any health problems? ___ Yes ___ No
If yes, please specify: _____
Please indicate which of the following communicable diseases your child has had.
___ Chicken Pox ___ Diphtheria ___ Measles ___ German Measles ___ Mumps
___ Influenza ___ Pneumonia ___ Scarlet Fever ___ Whooping Cough
Please indicate whether your child has any persistent problems with any of the following:
___ Asthma ___ Colds ___ Coughs ___ Headaches ___ Stomach aches
___ Hay fever ___ Tonsillitis ___ Nose Bleeds ___ Epilepsy or Seizures
Others:_____
Does your child take any special medication for it? ___ Yes ___ No
If yes, please specify what medication: _____
Is your child up to date on his/her immunizations? ___ Yes ___ No
Has your child had any serious accidents that required him/her to be hospitalized? ___ Yes ___ No
If yes, please specify: _____
Has your child had any operations? ___ Yes ___ No If yes, please specify:_____
Does your child wear glasses? ___ Yes ___ No Date of last Eye Exam? _____
Does your child have regular dental check ups? ___ Yes ___ No
Date of last dental check up?_____
Does your child have any hearing problems? ___ Yes ___ No
Date of last Hearing Exam? _____
Does your child have any allergies? ___ Yes ___ No If yes, please specify: _____
Does your child have any allergies to medicine? ___Yes ___No If yes, please specify: _____
____ Long term medications prescribed by medical doctor: _____
____ Short term medications-OTC: (e.g. Antibiotics) _____
***Need current parental consent for the Nurse or designated personnel to dispense such medication.*

EMERGENCY INFORMATION

Please indicate a contact person (other than parent or guardian) who has agreed to care for and provide transportation for your child in case he/she becomes ill or injured and you can not be reached. If you have a family physician, please write the name in case medical assistance is necessary.

Alternate Emergency Contact Name: _____
Relationship to Student: _____ Daytime Phone Number: _____
Family's Doctor Name: _____ Hospital Clinic: _____
Do you have medical insurance? _____ If yes, please specify: _____Clinic Phone #: _____

I hereby give my consent to the Administration at iLearn Academy Charter School to obtain emergency medical treatment for my child. School authorities must attempt to contact me before relying on this authorization.

Print Parent's Name & Signature: _____ Date: _____

I HEREBY CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Print Parent's Name & Signature: _____ Date: _____

v11.28.23

iLACS STUDENT PHYSICAL EXAMINATION

Student's Full Name: _____ **Date of EXAM:** _____

Phone: _____ Race: _____ Sex: ____

Address: _____ Birth date: _____ Age: _____

_____ Birth place: _____

Father's name: _____ Mother's name: _____

SCHOOL YEAR:

A. -HISTORY OF IMMUNIZATIONS, DISEASES, OPERATIONS, INJURIES-

IMMUNIZATION OR DISEASE	DATE OF ILLNESS	DATE OF IMMUNIZATION	LAST BOOSTER
DIPHTHERIA			
PERTUSSIS (whooping cough)			
TETANIUS			
POLIO - O			
POLIO - S.			
MEASLES (Rubeola)			
SMALLPOX			
MUMPS			
GERMAN MEASLES (Rubella)			
OTHER( )			

	DATE	COMMENTS
CHICKENPOX		
SCARLET FEVER		
RHEUMATIC FEVER		
DIABETES		
ALLERGY (type?)		
SEIZURES		
INJURY, FRACTURE		
OPERATION		
OTHER /ALLERGIES (specify)		

— will refer to the updated Immunization Record —

TUBERCULIN TEST (type) DATE: NEGATIVE: ☐ POSITIVE: ☐ X-RAY?

STUDENTS LAST NAME:

B. PHYSICAL EXAMINATION HEIGHT: WEIGHT: BLOOD PRESSURE:

CHECK (✓) ONLY IF ABNORMAL OR NEEDS FOLLOW UP				PHYSICIAN'S COMMENTS, FINDINGS, TESTS (use back side if needed)
NUTRITION				
NEUROLOGIC				
ORTHOPEDIC (incl. arches)				
SKIN, SCALP				
EYES	R	L		
VISUAL ACUITY	R	L		HAS GLASSES? CONTACT LENSES?
COLOR VISION				
EARS	R	L		
AUDITORY ACUITY	R	L		HAS HEARING AID?
SPEECH				
NOSE, THROAT				
MOUTH, TEETH				
GLANDS, THYROID				
HEART, LUNGS				
ABDOMEN				
GENITALIA				

C. ~~LABORATORY~~ (if needed) ~~HEMOGLOBIN: GM., HEMATOCRIT: %, URINE: FECES:~~ N/A

STUDENTS FIRST NAME:

D. PHYSICIAN CHECK (✓) BOX:	NO	YES	PHYSICIAN'S COMMENTS (use back side if needed)
EMOTIONAL/MENTAL/BEHAVIOR PROBLEM			
HEALTH HABITS PROBLEM			
PHYSICAL DISABILITY -- LIMITS ACTIVITY			
RESTRICTION NEEDED			
ENCOURAGE PARTICIPATION			
OTHER DISABILITY			
SEIZURES			
ON MEDICATION ( )			
FOLLOW-UP RECOMMENDED			
FOLLOW-UP COMPLETED			

This student has completed the immunizations required by the Government: YES____ NO____ and in my opinion is free of any communicable disease and may be admitted to school YES ____ NO ____

Student's usual Physician: _____ Examining Physician: _____

Telephone#: _____ Telephone#: _____ License #: _____

In my opinion, this student is _____/ is not _____ physically qualified to participate in athletics ____, driver education ____, other _____ as of (date) _____

Examining Physician: _____ **Telephone#:** _____ **License #:** _____

Physician and/or Clinic STAMP HERE