Registration Process

Step 1: **Online Registration**: Enter the required information in our online registration system in one of the following ways:

1. Go to our website at ***capetigers.com/districtinfo/newtocapeschools*** to access it from your home computer or …
2. Use one of the kiosk computers at the district's Central Administration Office to complete online registration

Step 2: **Additional Forms**: Complete the "***Additional Forms***" by choosing one of the following options:

1. Print the forms and complete them or …
2. Pick up the forms from the Central Administration Office and complete them

Step 3: **Registration Appointment**: Call the Central Administration Office to schedule an appointment to meet with the Registrar.

Registrar - Carrie Lattimer
Central Administration Office
301 N. Clark Ave.
573-335-1867

You will need to bring the following documents to this appointment:

- Completed "***Additional Forms***" packet(s) – One for each student
- Student's Original Birth Certificate (or passport, visa, hospital record)
- Student's Immunization Record
- Student's Social Security Card (provision of SSN is voluntary)
- Parent/Guardian Photo ID
- Proof of Residency (utility bill/agreement, rental agreement/receipt, property tax statement for the residence, real estate contract)
    - If you are unable to provide proof of residency in your name because you are living with another person/family, then the person with whom you are living should also attend the meeting with the registrar and provide proof of residency in his/her name.

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Additional Registration Form
Developmental and Health History

Date: _____

Date Immunization Record verified::

Student

Student
Name/Grade/Gender: _____ Grade: _____ ☐ Male Or ☐ Female

Birth Date: mm/dd/yyyy _____ Age: _____

Parent/Guardian Name(s): _____ Phone #: _____

Immunization Records

Copy of Immunization Record attached? ☐ Yes ☐ No

Name of clinic where immunization(s) received: _____

City: _____ State: _____ Phone #: _____

Growth & Development

Did you have any problems during the pregnancy? ☐ Yes ☐ No

If yes, explain _____

Were there any problems at the time of the birth of this child? ☐ Yes ☐ No

If yes, explain _____

Did this child meet the normal developmental stages such as crawling, walking, and talking as expected? ☐ Yes ☐ No

If no, explain _____

Childhood Illnesses

Please indicate IF and WHEN your child had:

Chickenpox	☐ Yes	☐ No	Date:	_____
Measles	☐ Yes	☐ No	Date:	_____
Mumps	☐ Yes	☐ No	Date:	_____

Allergies

Has this child ever experienced allergies to *Food* or *Medications?* ☐ Yes ☐ No

If yes, please list the allergy and describe the reaction _____

Has this child ever experienced allergies to *Bee Stings*? ☐ Yes ☐ No

If yes, please describe the reaction _____

Is emergency medication required? ☐ Yes ☐ No

Illness/Accident/Hospitalization/Surgery

If this child has had any of the following, please explain providing the month and year:

Major Illness	☐ Yes	☐ No	Month/Year:		Explain:	
Serious Accident	☐ Yes	☐ No	Month/Year:		Explain:	
Hospitalizations	☐ Yes	☐ No	Month/Year:		Explain:	
Surgeries	☐ Yes	☐ No	Month/Year:		Explain:	

Medications

Medications	Dosage	Frequency (how often per day)	Reason for Taking

*Will your child require medications at school? ☐ Yes ☐ No

*If yes, please see the school nurse to complete the school Medication Permission Form.

Health Concerns

Has your child, in the past or present, had problems with the following? If yes, please explain.

EYES

Crossed Eyes/Drifting Eyes	☐ Yes	☐ No		
Itching/Burning/Redness	☐ Yes	☐ No		
Excessive Tearing/Watering	☐ Yes	☐ No		
Wears Glasses/Contacts	☐ Yes	☐ No		

EARS / NOSE / THROAT

Seasonal Allergies/Hay Fever	☐ Yes	☐ No		
Runny Nose/Post Nasal Drip	☐ Yes	☐ No		
Sinus Congestion	☐ Yes	☐ No		
Frequent Nose Bleeds	☐ Yes	☐ No		
Frequent Ear Infections	☐ Yes	☐ No		
Difficulty Hearing	☐ Yes	☐ No		
Wears Hearing Aid	☐ Yes	☐ No	If yes, check one or both:	☐ Right ☐ Left

RESPIRATORY / LUNGS

Chronic Cough/Chronic Bronchitis	☐ Yes	☐ No		
Asthma	☐ Yes	☐ No	If yes, what triggers attack?	
*Does child use an inhaler on a daily basis?	☐ Yes	☐ No	If yes, please name:	

*If this child uses an inhaler, please see the school nurse for the Medical Permission Form(s).

CARDIAC					
Heart Condition	☐	Yes	☐	No	
Heart Murmur	☐	Yes	☐	No	
ENDOCRINE					
Thyroid Disorder	☐	Yes	☐	No	
*Diabetes	☐	Yes	☐	No	
Does this child take insulin?	☐	Yes	☐	No	If yes, list types:
How often is blood sugar checked?					

*If this child is diabetic, please see the school nurse to complete the Diabetic Health Care Plan.

LYMPHATIC / HEMATOLOGY					
Anemia	☐	Yes	☐	No	
Bleeding Disorder	☐	Yes	☐	No	
Cancer	☐	Yes	☐	No	
NEUROLOGICAL					
Headaches/Migraines	☐	Yes	☐	No	
Seizures/Epilepsy	☐	Yes	☐	No	If yes, date of last seizure:
Is child presently under a doctor's care for seizures?	☐	Yes	☐	No	
Is child currently taking medication for seizures?	☐	Yes	☐	No	
GASTROINTESTINAL					
Stomach Problems	☐	Yes	☐	No	
Diarrhea/Constipation	☐	Yes	☐	No	
Dietary Restrictions	☐	Yes	☐	No	
*Special Diet Required	☐	Yes	☐	No	

*If a special diet is required, a doctor will need to complete the school Dietary Modification Form.

BLADDER / KIDNEYS					
Kidney Disorder	☐	Yes	☐	No	
Frequent Bladder Infections	☐	Yes	☐	No	
Needs to use bathroom frequently	☐	Yes	☐	No	
Bed Wetting	☐	Yes	☐	No	
Requires Diapering or Catheterizations	☐	Yes	☐	No	

BONES / JOINTS / MUSCLES / SKIN

Rheumatoid Arthritis	☐	Yes	☐	No	
Muscle Disorder or Pain	☐	Yes	☐	No	
Bone or Joint Disorder or Pain	☐	Yes	☐	No	
Skin Disorder / Scars	☐	Yes	☐	No	
*Condition that prevents PE participation?	☐	Yes	☐	No	

*A condition that prevents PE participation will require documentation from the child's doctor stating the restriction.

Health Care Providers

Does your child have a family doctor? ☐ Yes ☐ No Dr.'s Name: _____

Dr.'s Phone #: _____ Date of last visit: _____

Does your child have a dentist? ☐ Yes ☐ No Dentist's Name: _____

Dentist's Phone #: _____ Date of last visit: _____

Hospital Preference: _____

Verification Section

I GIVE MY PERMISSION FOR THE ABOVE HEALTH INFORMATION TO BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL ON A CONFIDENTIAL HEALTH CONCERN LIST. ☐ Yes ☐ No

Name: _____ Relationship to Student: _____

Signature: _____ Date: _____

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Registration Form
Request for Student Records

Date of Request: _____

Student Name: _____

Birthdate: _____ Current Grade: _____

The Missouri Safe Schools Act states within forty-eight hours of enrolling a pupil, the school official enrolling the pupil, including any special education pupil, shall request records required by district policy for student transfer and those discipline records required by subsection 7 of section 160.261 RSMo, from all schools previously attended by the pupil within the last twelve months. Any public school district that receives a request for records from another school shall respond to such request five (5) business days upon receiving a request. ***Based on the language of the Act, the district may not hold the records until fees are paid.***

School Transferring From:

_____
(School Name)

_____
(School Address)

_____
(City, State, Zip)

_____
(Phone #)

_____
(Fax #)

We have just completed registration of this student in our school district. We would appreciate receiving the following information from you so that we might quickly move to complete his/her enrollment needs.

We request the following records:

Cumulative permanent school records including test scores and attendance records, transcripts of high school credits beginning with 9th grade, health and immunization records, interpretation of your marking system, psychological reports, discipline records including if the student is currently suspended or expelled with effective dates, special education records including evaluations and current IEP, and whether or not the student has passed the U.S. Constitution test and the Missouri Constitution test.

The *Family Education Rights and Privacy Act* (FERPA) allows schools to disclose a student's education records, without consent, to other schools to which a student is transferring (34 CFR § 99.31).

Send Records To:
(All addresses are in Cape Girardeau, MO)

Alma Schrader Elementary
Attn: Kathy Swoboda
1360 Randol Avenue
Zip: 63701
Phone:573-335-5310
Fax:573-334-3871
School Code: 4020

Blanchard Elementary
Attn: Stacia Hester
1829 N. Sprigg St.
Zip: 63701
Phone:573-335-3030
Fax:573-334-1319
School Code: 4050

Clippard Elementary
Attn: Teresa Ratliff
2880 Hopper Road
Zip: 63701
Phone:573-334-5720
Fax:573-334-1067
School Code: 4060

Franklin Elementary
Attn: Tina Wright
1550 Themis St.
Zip: 63701
Phone:573-335-5456
Fax:573-334-1140
School Code:4040

Jefferson Elementary
Attn: Leah Braswell
520 S. Minnesota St.
Zip: 63703
Phone:573-334-2030
Fax:573-334-1159
School Code: 4080

Central Middle School
Attn: Christie Ralls
1900 Thilenius St.
Zip: 63701
Phone:573-519-0653
Fax:573-334-1411
School Code: 4090

Central Junior High
Attn: Beverly Essner
205 Caruthers St.
Zip: 63701
Phone:573-519-0663
Fax:573-335-7173
School Code: 2050

Central High School
Attn: Jacki Ainsworth
1000 S. Silver Springs Rd.
Zip: 63703
Phone:573-334-1111
Fax:573-334-1147
School Code: 1050

Central Academy
Attn: Sandy Elfrink
330 N. Spring Avenue
Zip: 63701
Phone: 573-335-5939
Fax: 573-335-6041

Cape Girardeau Public Schools
Attn: Dana Dickerson
1829 N. Sprigg St.
Zip: 63701
Phone: 573-290-5888
Fax: 573-335-0495

_____ Date: _____
(Signature of Parent or Legal Guardian)

_____ Date: _____
(Signature of Registrar)

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Additional Registration Form
Parent Portal Application

Cape Girardeau Public Schools has a tool for parents to access student information (attendance, grades, etc.) as well as to make online payments for lunch accounts. It is called "Infinite Campus Parent Portal." For access to this useful tool, complete the form below and submit it to your child's school office or to the Registrar at the school district's Central Administration Office. You will need to provide a photo ID when you submit your form. Be sure to list all of your enrolled students and provide your signature at the bottom. Any questions on registration/access to the parent portal should be addressed to the Registrar at 573-335-1867 or lattimerc@capetigers.com.

Parent Information:

Parent/Guardian Name (First & Last): _____

Username (whatever you choose): _____

Cell Phone Number: _____

Street Address: _____

City/State/Zip Code: _____

Student Information:

Name (First & Last)	Birthdate	Grade	Relationship to Adult Above

Parent Signature: _____ Date: _____

(For School Personnel Use)	Building	Date	Staff Initials
Parent ID Verified by:			
Entered in Infinite Campus			

REQUEST FOR INFORMATION

(Complete one form per family)

Please answer the question below by checking the appropriate box. The following information is a request adopted by the General Assembly in 2010 requiring school districts to determine whether or not all children in a family have health insurance.

Does each child in your family have healthcare insurance?

☐ YES

☐ NO

MO HealthNet (Medicaid) is considered healthcare insurance.

If NO is checked the school district will provide the Does Your Child Need Healthcare Coverage form for the family.

Completion of this form is not a condition of determining meal eligibility. The Free and Reduced Price Meals Family Application will be reviewed regardless of your response to this Request for Information.

Submit this request with your Free and Reduced Price School Meals Family Application or return to your school/school district.

Printed name of parent/guardian: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____