# Emerson Jump Start Registration 2025

1.Child First Name _____

2.Child Last Name _____

3.What's your child's preferred first name? _____

4.Date of birth _____

5.Gender _____

6.Address _____

7.Zip Code _____

8.Primary Parent Guardian First Name _____

9.Primary Parent Guardian Last Name _____

10.Primary Parent Guardian Cell Phone Number _____

11.Primary Parent Guardian Work/Home Phone Number _____

12.Primary Parent Guardian Email Address _____

13.Secondary Parent Guardian First Name _____

14.Secondary Parent Guardian Last Name _____

15.Secondary Parent Guardian Cell Phone Number _____

16.Secondary Parent Guardian Work/Home Phone Number _____

17.Secondary Parent Guardian Email Address _____

18.Family Primary Language _____

19.An Interpreter required Yes No

20.Do you have any other children that attend this school? Yes No

21.If you have other children that attend Emerson Elementary School, please list their names and grade. _____

22.Emergency Contact Name (person who you authorize to pick up your child in an emergency situation) _____

23.Emergency Contact relationship with the student _____

24.Emergency Contact Cell Phone Number _____

25.Emergency Contact Work/Home Phone Number _____

26.Emergency Contact Name (person who you authorize to pick up your child in an emergency situation) _____

27.Emergency Contact relationship with the student _____

28.Emergency Contact Cell Phone Number _____

29.Emergency Contact Work/Home Phone Number _____

30.Photo/Video Permission: Do you give permission for your child to be included in photos or videos during Jump Start for school use only? Yes No

31.My student has known health concerns. Yes No

32.Allergy/Anaphylaxis: Please describe the child's individualized health plan (IHP) for this allergy. _____

33.What is the student allergic to? _____

34.Does the student have an epinephrine auto injector rescue prescription? Asthma with rescue medication (for example: rescue inhaler) Yes No Not Applicable

35.Does the student use rescue inhaler routinely for asthma symptoms? Yes No

36.Has your child been hospitalized for asthma in the past year? Yes No

37.Has your child used steroids (prednisone) for asthma symptoms in the past year? Yes No

38.Seizure Disorder: Please describe the student's individualized health plan (IHP) for seizures. _____

39.If your child needs emergency medication for seizure, what is the medication?

_____

40.Diabetes: Please attach student's individualized health plan (IHP) for diabetes.

_____

41.My student has _____ for diabetes.

Insulin Pump Insulin Pen Injected Insulin

42.If child has any other health issues, please indicate issue or treatment needed:

_____

43.My child has an Individual Health Plan (IHP):

_____

44.My child's condition is life threatening:

_____

45.My child currently takes the following medications:

_____

46.My child needs these treatments: (tube feeding, suctioning, toileting and etc.:)

_____

47. *Before Jump Start: If your child has a serious health concern requiring medication at school, send your school the Individual Health Plan (IHP) & an Authorization for Medication. Call (206) 252-0750 (SPS Health Services) for help or questions. Without these, an adult family member will need to stay onsite at Jump Start in case of an emergency.* I understand the requirements. Parent signature _____

48.What will help your child feel comfortable participating at school?

_____

49.What can staff do to help your child make friends and enjoy Jump Start?

_____

50.Does your child have a: Individualized Education Plan (IEP): Yes No

51.Does your child have 504 Plan? Yes No

52. *Before Jump Start: If you have concerns about your child, or your child has an IEP or 504, we'd like to talk with you to plan together. Please call your school to speak with the Assistant Principal or Principal.*

I understand the requirements. Yes No

53. Parent full name (please print)_____

54. Parent signature _____

55.Date _____