

**DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT REGISTRATION
SY _____ / _____**

OMB No.
OMB approval expires

The public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (XXXX-XXXX). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE SCHOOL IN WHICH THE STUDENT IS ENROLLING.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Section 2164, and 20 U.S.C. Sections 921-932.

PRINCIPAL PURPOSE(S): 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>.

ROUTINE USE(S): To Federal, State and local government officials to protect 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.

This form is completed by the **sponsor**, an active duty military member or a full-time DoD civilian to request enrollment of his/her dependent(s) at a DoDEA school. A **dependent** is a minor individual who has not completed secondary schooling and who is the child, stepchild, adopted child, ward or spouse of the sponsor. The information collected is used internally to determine the student's eligibility to enroll on a tuition-free or tuition-paying basis, and whether the student is space-required or space-available. It is also used to ensure that DoDEA makes available the appropriate classrooms, staffing, and supportive educational services, places students in the appropriate grade, identifies students with special needs, and to ensure compliance with laws protecting student rights.

SECTION I - SPONSOR INFORMATION

1. TITLE	2.a. SPONSOR LAST NAME	b. SPONSOR FIRST NAME	c. SPONSOR MIDDLE NAME	3. RELATIONSHIP TO STUDENT
4. TELEPHONE NUMBERS (Include Area Code or DSN)			5. EMAIL ADDRESS	
a. HOME	b. DUTY/WORK	c. CELL		
6. ORGANIZATION			7. PAY GRADE	8. ROTATION/DEPARTURE DATE (YYYYMMDD)
9. EMPLOYMENT ADDRESS				

D R A F T

10. MAILING ADDRESS (e.g., Local/APO/FPO) (Required)	11. PHYSICAL QUARTERS (Street, City, etc.) (Enter only if different from mailing address)
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SECTION II - SPONSOR'S SPOUSE INFORMATION

1. TITLE	2.a. SPOUSE LAST NAME	b. SPOUSE FIRST NAME	c. SPOUSE MIDDLE NAME	3. RELATIONSHIP TO STUDENT
4. TELEPHONE NUMBERS (Include Area Code or DSN)			5. EMAIL ADDRESS	
a. HOME (If different)	b. DUTY/WORK	c. CELL		
6. EMPLOYMENT ADDRESS				

SECTION III - LOCAL EMERGENCY CONTACT AND RELEASE INFORMATION

The person identified will be contacted if there is an emergency and the sponsor/spouse cannot be contacted. I permit the dependents that I am registering with this form to be released to the emergency contact identified in this section if I or my spouse are not available.

1. LAST NAME (Not sponsor or spouse)	2. FIRST NAME	3. TITLE	4. RELATIONSHIP TO STUDENT
5. HOME TELEPHONE	6. DUTY/WORK TELEPHONE	7. CELL PHONE	

SECTION IIIA - LOCAL EMERGENCY CONTACT AND RELEASE INFORMATION

The person identified will be contacted if there is an emergency and the sponsor/spouse or the emergency contact cannot be contacted. I permit the dependents that I am registering with this form to be released to the emergency contact identified in this section if I or my spouse are not available.

1. LAST NAME (Not sponsor or spouse)	2. FIRST NAME	3. TITLE	4. RELATIONSHIP TO STUDENT
5. HOME TELEPHONE	6. DUTY/WORK TELEPHONE	7. CELL PHONE	

SECTION IIIB - PERMANENT STATESIDE EMERGENCY CONTACT INFORMATION

1. LAST NAME	2. FIRST NAME	3. TITLE	4. RELATIONSHIP TO STUDENT
5. HOME TELEPHONE	6. DUTY/WORK TELEPHONE	7. CELL PHONE	

8. PERMANENT STATESIDE ADDRESS

SECTION IV - STUDENT INFORMATION

1.a. LEGAL LAST NAME		b. LEGAL FIRST NAME		c. LEGAL MIDDLE NAME		d. PREFERRED FIRST NAME	
2. GENERATION		3. GENDER (X one) <input type="checkbox"/> M <input type="checkbox"/> F		4. DATE OF BIRTH (YYYYMMDD)		5. STUDENT ETHNICITY: HISPANIC OR LATINO (X one) <input type="checkbox"/> Y <input type="checkbox"/> N	
6. STUDENT RACE (X all that apply)							
<input type="checkbox"/> a. American Indian or Alaska Native		<input type="checkbox"/> c. Black or African American		<input type="checkbox"/> e. Native Hawaiian or Other Pacific Islander			
<input type="checkbox"/> b. Asian		<input type="checkbox"/> d. White					
7. STUDENT CELL PHONE (Include Area Code)		8. STUDENT EMAIL ADDRESS (May be assigned by school)			9. PASSPORT NUMBER (H.S. only)		10. PASSPORT EXPIRATION DATE (YYYYMMDD)
11. DOES THE STUDENT SPEAK A LANGUAGE OTHER THAN ENGLISH IN THE HOME? (X one) <input type="checkbox"/> Y <input type="checkbox"/> N			12. IS THERE AN ADULT WHO SPEAKS A LANGUAGE OTHER THAN ENGLISH? (X one) <input type="checkbox"/> Y <input type="checkbox"/> N			18. WHAT IS THE HOME LANGUAGE?	

SECTION V - HEALTH INFORMATION

The information for physical and medical facility is for use in an emergency. Other information is collected to ensure compliance with immunization requirements and provide staff with the student's medical background.

1. PHYSICIAN OR MEDICAL FACILITY NAME		2. PHYSICIAN OR MEDICAL FACILITY TELEPHONE NUMBER (Include Area Code or DSN)	
3. ALLERGIES			
4. CURRENT MEDICATIONS (Prescribed or over the counter)			
5. IMMUNIZATIONS (X and initial) <input type="checkbox"/> I have provided or <input type="checkbox"/> will provide a copy of the Immunization Record. INITIAL: _____ DATE: (YYYYMMDD) _____			
6. OTHER CONCERNS			
D R A F T			
7. DOES THE STUDENT HAVE A HEALTH CONDITION REQUIRING POSSIBLE EMERGENCY CARE? (X one) <input type="checkbox"/> Y <input type="checkbox"/> N (If Yes, specify:)			

SECTION VI - VERIFICATION

1. I AM REGISTERING _____ (Number) STUDENT(S).	
2. I declare under penalty of perjury that the statements made by me on this form are true, complete and correct.	
a. SIGNATURE OF SPONSOR/LEGAL GUARDIAN	b. DATE (YYYYMMDD)

SECTION VII - FINAL DETERMINATION

The final determination for placement of a child in a DoDEA school is the responsibility of DoDEA. You may be provided the opportunity to personally explain, refute, or clarify any information before a final decision is made.

SECTION VIII - SCHOOL USE

1. STUDENT NUMBER		2. STUDENT GRADE		3. ENROLLMENT CODE		4. ENTRY CODE	
5. SCHOOL NAME				6. FIRST DAY STUDENT STARTS SCHOOL (YYYYMMDD)			
7. ORDERS ON FILE/VERIFIED (X one) <input type="checkbox"/> Y <input type="checkbox"/> N				8. BIRTH DATE VERIFIED (Pre-Kindergarten, Sure Start, Kindergarten, First Grade) <input type="checkbox"/> Y <input type="checkbox"/> N			
9. I verify that the information is correct.							
a. SIGNATURE OF REGISTRAR						b. DATE (YYYYMMDD)	