



Today's Date \_\_\_\_\_

Start Date \_\_\_\_\_

School Year \_\_\_\_\_

New Enrollee

Re-Enrollee

Transfer within district

School of Choice

**SPECIAL HELP**

Has your child ever received special education services?  Yes  No

Does your child have a current IEP?  Yes  No

Has your child received Title I (Remedial) services?  Yes  No

Is your child currently on a 504 Plan?  Yes  No

(Initials of staff member obtaining this information \_\_\_\_\_)

**STUDENT INFORMATION**

Legal Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_

Male  Female City of Birth \_\_\_\_\_ Previous School \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

**Ethnicity (choose one)**

- Hispanic or Latino
- Not Hispanic or Latino

**Race (choose one or more, regardless of ethnicity)**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

**PARENT INFORMATION- ONLY PARENT/GUARDIAN MAY ENROLL STUDENT**

Name of parents/guardians with whom student resides- include last name if different from student.

FEMALE

MALE

Name \_\_\_\_\_

Name \_\_\_\_\_

Relationship to student \_\_\_\_\_

Relationship to student \_\_\_\_\_

Court appointed guardian?  Yes  No

Court appointed guardian?  Yes  No

Cell Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

**PARENTS LIVING ELSEWHERE (DIVORCED PARENTS)**

**SEND MAIL?**  Yes  No

Name \_\_\_\_\_

Relationship to student \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

P  
 S  
 M  
 C  
 I  
 R  
 R  
 R  
 M  
 S  
 D  
 S

**MEDICAL CONDITIONS/ALLERGIES:**

\_\_\_\_\_

\_\_\_\_\_

Does your child take medication for this condition?  Yes  No  
 If yes, name of medication \_\_\_\_\_

If your child will need to take medication at school, please ask for a district Medication Form, which must be completed by your child's doctor.

**LIST OTHER CHILDREN IN FAMILY:**

Last Name	First Name	Sex	Birthdate	Grade	School he/she will attend
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**LANGUAGE SPOKEN IN THE HOME**

Is your child's native tongue a language other than English?  Yes  No

Is the primary language used in your child's home or environment a language other than English?  
 Yes  No

If yes, what is that language? \_\_\_\_\_

**MCKINNEY-VENTO ACT**

**Is your family living in any of the following situations? Please circle Y (yes) or N (no)**

In a motel, camp, or shelter due to the lack of alternative adequate accommodations? **Y** **N**

In a car, park, abandoned building or bus or train station? **Y** **N**

Doubled up with other people due to loss of housing or economic hardship? **Y** **N**

**If you answer yes to any of the above questions, your child may be eligible for special services. Our homeless liaison will contact you.**

**VERIFICATION OF INFORMATION-the undersigned acknowledges that the information provided on this form is true and accurate.**

Parent/Legal Guardian Signature

Date

**FOR SCHOOL USE ONLY**

TEACHER \_\_\_\_\_ STREET CODE \_\_\_\_\_ CENSUS CODE \_\_\_\_\_ BUS ROUTE \_\_\_\_\_

**VERIFICATION:**

- BIRTH CERTIFICATE  RESIDENCY  IMMUNIZATIONS  RECORDS REQUESTED
- HEARING/VISION SCREENING (KDG.)  VARICELLA  CUSTODY PAPERS (IF APPLICABLE)

**EXIT INFORMATION:**

Exit Date \_\_\_\_\_ Next Building \_\_\_\_\_