ENROLLMENT FORM

Name:			Social Security #: - -
Street Address:			Box #:
City:	State:		Zip:
Grade:	Birthdate: / /		Birth Place:
Parent Status: (Circle One)	Married Divorced Separated Other: Mother Deceased Father Deceased		
Lives with: (Circle One)	Parents Mother only Father only Guardian Other:		
First Language:			Home Language:

Race and Ethnicity: (*Note: Both Part A and Part B of the question **must be** answered.*)

Part A:

Is this student Hispanic/Latino? *(Choose only one)*

☐ **No**, not Hispanic/Latino

☐ **Yes, Hispanic/Latino** (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)

The above part of the question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate what you consider your student's race to be.

Part B:

What is the student's race? *(Choose one or more)*

☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South American (including Central America), and who maintains tribal affiliation or community attachment.)

☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)

☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Male Head of Household Name:					
Relationship: (Circle One)	Father Brother	Grandfather Stepfather	Friend Other:	Guardian	Uncle
Employer:			Work Phone ( ) -		
Home Phone ( ) -			Mobil Phone ( ) -		
Female Head of Household Name:					
Relationship: (Circle One)	Mother Sister	Grandmother Stepmother	Friend Other:	Guardian	Aunt
Employer:			Work Phone ( ) -		
Home Phone ( ) -			Mobil Phone ( ) -		
Contact E-mail Address:					

Two Emergency Contact Names:

Name:	Name:
Relationship:	Relationship:
Home Phone ( ) -	Home Phone ( ) -
Work Phone ( ) -	Work Phone ( ) -
Mobil Phone ( ) -	Mobil Phone ( ) -

Sublette MS\HS
Health Enrollment

Student's Name: _____ **DOB:** _____
SSN: _____-_____-_____ **Sex:** Male ____ Female ____

Address: _____ **City/State:** _____
Zip Code: _____

Father's Name: _____ **Work Phone** ( )_____-_____
Mother's Name: _____ **Work Phone** ( )_____-_____
Home Phone ( ) _____-_____

Insurance Information:
Company Name: _____
Phone No.: _____ **Group No.:** _____

Student's Grade this Year: _____ **Teacher:** _____
Room No.: _____

Medical Alert (allergies, seizures, hypoglycemic, etc.) :

1. _____
2. _____
3. _____

Contacts (who to call in case of emergency with priority designated):

1. _____
2. _____
3. _____

Ethnicity (please check):
Non-Hispanic ____ Hispanic ____

Race (please check all applicable):
Native Hawaiian ____ Pacific Islander ____ White ____ Samoan ____
Vietnamese ____ American Indian ____ Alaskan National ____

Immunization Record:

Vaccine	Due Now/Current	Due Next/Complete	Dose Given
DTaP	_____	_____	_____
Hep B	_____	_____	_____
Hib	_____	_____	_____
MMR	_____	_____	_____
Polio	_____	_____	_____
TB Booseter	_____	_____	_____
Varicella	_____	_____	_____
PCV-7	_____	_____	_____

Family History (parents, grandparents, sibilings):

	Relationship	Illness/Disease/Symptoms
1.	_____	_____
2.	_____	_____
3.	_____	_____

Medical Information (please list any current illness, disease, or conditions requiring medical attention):

1. _____
2. _____
3. _____

Assistive Devices (please list glasses, contact, etc. used by child):

1. _____
2. _____
3. _____

Special Problems (eye strain, difficulty breathing, etc.):

1. _____
2. _____
3. _____

Organizations (please list pharmacy used for prescriptions, family Doctor, name of clinic visited):

Pharmacy _____ Doctor _____

Clinic Site _____ Other _____

Prescriptions to be given by School Nurse (please list):

1. _____
2. _____
3. _____

Unified School District # 374
Sublette, Kansas 67877
HOME LANGUAGE SURVEY
GRADES K-12

TO BE FILLED OUT BY PARENT/GUARDIAN:

What language did your child began to speak first? ☐ *English* ☐*Spanish* ☐*German*
What language(s) is spoken in your home? ☐*English* ☐*Spanish* ☐*German*
What language(s) does your child speak? ☐*English* ☐*Spanish* ☐*German*

¿Cual idioma aprendió su hijo/a hablar primero? ☐*Ingles* ☐*Español* ☐*Alemán*
¿Cual es el idioma(s) que hablan en su hogar? ☐*Ingles* ☐*Español* ☐*Alemán*
¿Cual es el idioma(s) que habla su hijo/a(s)? ☐*Ingles* ☐*Español* ☐*Alemán*
¿Necesita intérprete para las conferencias? ☐*Si* ☐*No*
¿Quiere la información de la escuela en español? ☐*Si* ☐*No*

Welche sprache lhren kindafang gemacht hat, zuerst su sprechen? ☐*Englisch* ☐*Spanisch* ☐*Deutsch*
Welche sprache wird in euer heim an meisten gesprachen? ☐*Englisch* ☐*Spanisch* ☐*Deutsch*
Welche sprache redet euer kind an mersten? ☐*Englisch* ☐*Spanisch* ☐*Deutsch*
Felht dir eine person was deutsch redet fuer die eltern? ☐*Ja* ☐*Nein*
Willst du die briefe im deutschen gesardt haben? ☐*Ja* ☐*Nein*

Student(s) Name(s):	**Grade:**	**Language(s):**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Signature/Firma/Unterschrift

Date/Fecha/Datum

PERMISSION SLIP
TO
LEAVE CAMPUS

My child, _____, has permission to leave campus for school-sponsored events during the 2007-2008 school year.

These trips may include, but are not limited to:

- Field Trips
- Yearbook Trips
- Home Ec Trips
- Club Trips

Parent Signature: _____

Date: _____

EMERGENCY CARE FORM

During the coming year your child may be injured or become ill during athletic practices, contests or activity trips. Many of these contests and activities will, of course, be out of town. In the event your child is injured or becomes ill, attempts will be made to contact the parent/guardian. Please help us care for your child by filling in the necessary information below.

_____ _____ _____
STUDENT'S NAME GRADE HOME PHONE NUMBER

MOTHER'S NAME: _____ WORK PHONE NUMBER: _____

FATHER'S NAME: _____ WORK PHONE NUMBER: _____

If you cannot be reached at home or at work, where else might you be contacted? Include appropriate phone numbers or cell numbers.

_____

Please designate persons who will care for your child or help make emergency decisions in case a parent/guardian cannot be reached. (These may well be close friends or relatives who normally attend your child's contests or activities.)

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

In the event of serious injury, it may be necessary to contact local emergency medical personnel immediately. Attempts will then be made to contact the parents/guardians or designated persons to inform them of the situation. The child will be treated by medical personnel as needed.

IMPORTANT MEDICAL INFORMATION

ALLERGIES/MAJOR HEALTH PROBLEMS: _____

_____

FAMILY PHYSICIAN: _____

_____
CONTACT PHONE NUMBER'S

INSURANCE POLICY: _____

INSURANCE NUMBER: _____

In case of an illness or injury to the above named student, the school is authorized to proceed in its emergency medical plan. I understand that the school is not financially responsible for individual medical, dental, ambulance, or hospital services. I realize that it will be necessary for me to inform the school of any address or phone number changes that may occur during the school year. I understand that the coaches/sponsors of my child will be prepared to take the appropriate emergency steps by keeping a copy of this form with them at all contests and activities.

_____ _____
Parents/Guardians' Signature Date

I give permission for the exchange of information between the school nurse or other school representative and the student's medical provider. I also give permission for the school nurse or other school representative to copy and send this student's immunization records to schools, physician's offices, and health departments as needed.

_____ _____
Parents/Guardians' Signature Date

Transportation 2010-2011

Family's Last Name: _____

Children's Names: _____

Do you live in town or in the country? Town: ☐ Country: ☐

If you live in the country what is your physical address:

_____

Phone Numbers

	Home	Cell Phone	Work	Other	Other
Mother:					
Father:					
Nearest Neighbors:			Home	Cell Phone	Work

Directions to your home from Sublette:

_____

_____

_____

_____

Will your student(s) ride the bus? Yes: ☐ No: ☐

If no one is at home when we arrive to drop off your child(ren) after school, what do you want the driver to do?

☐ Drop your child off anyway.
☐ Take my child back to the school and continue trying to call me.
☐ Other: _____

Mud Routes

Some parents elect to have their child(ren) walk home from their mud route stop. Do you want us to allow your child to:

☐ Walk home from the mud stop.
☐ Take my child back to the school and continue trying to call me.
☐ Other: _____

_____ _____

Parent Signature Date