ENROLLMENT FORM - Menomonee Falls School District *(Revised June 2017)*

Please use ballpoint pen and print clearly

SCHOOL INFORMATION

Date student will begin school: _____

Grade when student begins school: _____ School where student will attend: _____

Previous school attended: _____ School District: _____

Previous School Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

STUDENT INFORMATION

_____ _____ _____ Gender: ☐ Male ☐ Female

Legal Last Name (as printed on Birth Certificate) *Legal First Name* *Middle*

_____

Preferred Name (if different from Legal First Name)

_____ _____ **WI** _____

Mailing Address *City* *State* *Zip Code*

_____

Phone #

Student Expulsion: ☐ YES ☐ NO If "YES" please indicate the following: ☐ Current ☐ Prior/Pending *(administrator approval needed)*

STUDENT VITALS

Date of Birth: _____

County of Birth: _____

City of Birth: _____

State of Birth: _____

Date of Entry in USA *(if applicable):* _____

Date of Entry in to US schools (*if applicable):* _____

ETHNICITY

Please answer BOTH questions

(1). Is the person enrolling Hispanic or Latino? ☐ Yes ☐ No

(2). Please select the ethnicity of the student enrolling:

Choose one or more; you must choose at least one

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Pacific Islander

☐ White

HOME LANGUAGE INFORMATION

(1) Is a language **other** than English spoken in the home or on a regular basis? ☐ Yes ☐ No *If "Yes" list language(s):*

(2). Does the student use the language other than English on a regular basis? ☐ Yes ☐ No *If "Yes" list language(s):*

(3). Is the student currently receiving and or in need of "English Language Learning"services? ☐ Yes ☐ No

SPECIAL EDUCATION SERVICES INFORMATION

(1). Does the student have a written IEP (Individualized Education Plan), Section 504 Plan or Service Plan? ☐ Yes ☐ No *If "Yes" please indicate type of plan:* ☐ IEP ☐ Section 504 Plan ☐ Service Plan

(2). Briefly describe type of services/disability: _____

SIBLING INFORMATION

Child's Name (under 20 years old)	DOB (xx/xx/xx)	Gender	Ethnicity	School	Grade

TRANSPORTATION INFORMATION *Note: Open Enrollment students do NOT qualify for busing*

The student will be using the bus, if offered by the School District, as transportation to and from school? ☐ Yes ☐ No ☐ Not Applicable

PRIMARY CONTACT (*Primary Contact must be a person that the student resides with)*
PARENT/GUARDIAN #1 INFORMATION

Prefix: _____ First Name: _____ Last Name: _____ Middle Initial: ____

Relationship: ☐ Mother ☐ Stepmother ☐ Grandmother ☐ Foster Mother ☐ Other:
☐ Father ☐ Stepfather ☐ Grandfather ☐ Foster Father

☐ Student resides with this person ☐ Responsible for student ☐ Extra mailing needed?

Address (if different than students) _____ *City* _____ *State* _____ *Zip Code* _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext. _____

E-mail _____ *@xxxxx.com* _____

Employer _____ *Work Hours/Days* _____ *Occupation* _____

PARENT/GUARDIAN #2 INFORMATION

Prefix: _____ First Name: _____ Last Name: _____ Middle Initial: ____

Relationship: ☐ Mother ☐ Stepmother ☐ Grandmother ☐ Foster Mother ☐ Other:
☐ Father ☐ Stepfather ☐ Grandfather ☐ Foster Father

☐ Student resides with this person ☐ Responsible for student ☐ Extra mailing needed?

Address (if different than students) _____ *City* _____ *State* _____ *Zip Code* _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext. _____

E-mail _____ *@xxxxx.com* _____

Employer _____ *Work Hours/Days* _____ *Occupation* _____

PARENT/GUARDIAN #3 INFORMATION

Prefix: _____ First Name: _____ Last Name: _____ Middle Initial: ____

Relationship: ☐ Mother ☐ Stepmother ☐ Grandmother ☐ Foster Mother ☐ Other:
☐ Father ☐ Stepfather ☐ Grandfather ☐ Foster Father

☐ Student resides with this person ☐ Responsible for student ☐ Extra mailing needed?

Address (if different than students) *City* *State* *Zip Code*

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext. _____

E-mail *@xxxxx.com*

Employer *Work Hours/Days* *Occupation*

PARENT/GUARDIAN #4 INFORMATION

Prefix: _____ First Name: _____ Last Name: _____ Middle Initial: ____

Relationship: ☐ Mother ☐ Stepmother ☐ Grandmother ☐ Foster Mother ☐ Other:
☐ Father ☐ Stepfather ☐ Grandfather ☐ Foster Father

☐ Student resides with this person ☐ Responsible for student ☐ Extra mailing needed?

Address (if different than students) *City* *State* *Zip Code*

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext. _____

E-mail *@xxxxx.com*

Employer *Work Hours/Days* *Occupation*

EMERGENCY CONTACT INFORMATION

In all emergency situations the student's primary parent/guardian will be contacted first. The following people will be contacted if more information is needed to contact parent in an emergency situation.

Name *Relationship* *Phone #1* *Type* *Phone #2* *Type*

Name *Relationship* *Phone #1* *Type* *Phone #2* *Type*

SCHOOL MESSENGER - AUTOMATED ALERT SYSTEM

First Contact:

Name _____ *Relationship* _____

Home # _____ *Cell #* _____ *E-mail #1* _____

Work Phone # must be a direct line and not answered by an operator _____ Work #: _____ E-mail #2: _____

Second Contact:

Name _____ *Relationship* _____

Home # _____ *Cell #* _____ *E-mail #1* _____

Work Phone # must be a direct line and not answered by an operator _____ Work #: _____ E-mail #2: _____

Third Contact:

Name _____ *Relationship* _____

Home # _____ *Cell #* _____ *E-mail #1* _____

Work Phone # must be a direct line and not answered by an operator _____ Work #: _____ E-mail #2: _____

Fourth Contact:

Name _____ *Relationship* _____

Home # _____ *Cell #* _____ *E-mail #1* _____

Work Phone # must be a direct line and not answered by an operator _____ Work #: _____ E-mail #2: _____

DISTRICT INFORMATION **Please answer all 3 questions below after reviewing the Student/Parent Handbook found at: SDMF Handbook**

(1). ***My child has permission to take field trips within the school district limits.*** ☐ Yes ☐ No

(2). ***Per Board Policy 363.2, and as addressed in the SDMF Student & Parent Handbook, I provide consent for my child to use the District's technology and internet access.*** ☐ Yes ☐ No

(3). ***I have received, and will read, the SDMF Student & Parent Handbook and will share relevant topics with my child.*** ☐ Yes ☐ No

PARENT/GUARDIAN AGREEMENT & SIGNATURE

I, the undersigned, certify, under penalty of perjury, that the information provided is true and correct and the School District of Menomonee Falls may rely on this information to determine whether the parent and or student(s) are residents of the School District of Menomonee Falls.

_____ _____ _____

Parent/Guardian Name (printed) *Signature* *Date*

ANNUAL HEALTH HISTORY - Menomonee Falls School District

Health information will be shared with school staff on a need-to-know basis to ensure the safety of your child.

Student Information

Last Name | *First Name* | *Date of Birth* | *School* | *Grade*

Health Provider Information

Doctor's Name | *Doctor's Phone #* | *Dentist's Name* | *Dentist's Phone #*

Medical Information

☐ ***I have read the information below and my child does NOT have any of these needs or conditions.***

(1), Does your child take medication on a daily basis? If medications are to be given at school, please complete an Authorization to Administer Prescription Medication Form (including inhalers). For nonprescription medication the Authorization to Administer Over The Counter (non- prescriptive) Medications Form. Completed forms should be submitted to the school's office. All medication must be provided from the home in the original container, labeled and **must** be transported to school by the parent/guardian.

☐ AT HOME Please list medications and reason for taking below:

☐ AT SCHOOL Please list medications and reason for taking below:

(2), Does your child require special health care procedures at school? (Examples: toileting, blood sugar testing, catheterization, tube feeding, etc.)? If so, please complete information below:

Independently:

With Assistance:

If your child's physician has diagnosed your child with any of the conditions noted below, please check the appropriate box(es) and fill in additional requested information:

☐ ADD/ADHD Medication

Medications:

☐ Allergies (MUST provide symptom relief)

Animals: _____

Food: _____

Bees/Insects: _____

Latex/Other: _____

Date of Last Reaction: _____

Typical Symptoms:

☐ Asthma

Triggers: _____

Treatment:

☐ Bleeding Disorder

Specify/Explain:

☐ Behavioral/Mental Health

☐ Anxiety ☐ Depression

Other/Explain:

☐ Diabetes (*Note - all diabetic students must have glucagon to be stored in the school's health room)*

Medications: _____

Treatment:

☐ Ear or Hearing concerns

Hearing Aid: ☐ Right Ear ☐ Left Ear

☐ Eye or Vision concerns

☐ Glasses ☐ Contacts

☐ Feeding concerns

Specify/Explain:

☐ Heart conditions

Specify/Explain:

☐ Migraines or severe headaches

Specify/Explain:

☐ Seizures

Frequency: _____

Treatments:

☐ Other

Specify/Explain:

_____

Please note and include health conditions that are no longer an issue (ex: no longer has an allergy to peanuts)

_____

Please provide an Individualized Health Plan (IHP) to your school's health room. Forms can be found in the school's health room or on the district's website under "Health Care Forms"

_____ _____

Parent Signature *Date*