

ENROLLMENT FORM - Menomonee Falls School District

Please use ballpoint pen and print clearly

SCHOOL INFORMATION

Date student will begin school: _____ Grade when student begins school: _____

School where student will attend: _____ Neighborhood School (4K students only): _____

Previous school attended: _____ School District: _____

Previous School _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

STUDENT INFORMATION

Legal Last Name (as printed on Birth Certificate) _____ Legal First Name _____ Middle _____ Gender: Male Female

Preferred Name (if different from Legal First Name) _____

Mailing Address _____ City _____ State WI Zip Code _____

Phone # _____

Student Expulsion: YES NO If "YES" please indicate the following: Current Prior/Pending 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 *If "Yes" list*
 No *language(s):*
- (2) Does the student use the language other than English on a regular basis? Yes *If "Yes" list*
 No *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 *If "Yes" please indicate type of plan:* IEP
 No 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 bussing*

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 INFORMATION *Please select ONE parent/guardian to be the Primary Contact*

Primary Contact must be a person that the student resides with

Primary Contact Name (with whom student resides)

- Mother
 Father
 Guardian

PARENT/GUARDIAN #1 INFORMATION (PRIMARY CONTACT)

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 _____@xxxxxx.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 _____@xxxxxx.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 _____@xxxxxx.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

Primary Contact: Home #: _____ Cell #: _____ E-mail #1: _____

Work Phone # must be a direct line and not answered by an operator; no extensions

Work #: _____ E-mail #2: _____

Second Contact: Home #: _____ Cell #: _____ E-mail #1: _____

Work Phone # must be a direct line and not answered by an operator; no extensions

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 _____

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: _____

Ear or Hearing concerns

Hearing Aid: Right Ear Left Ear

Allergies (MUST provide symptom relief)

Animals: _____

Food: _____

Bees/Insects: _____

Latex/Other: _____

Date of Last Reaction: _____

Typical Symptoms: _____

Eye or Vision concerns

Glasses Contacts

Feeding concerns

Specify/Explain: _____

Heart conditions

Specify/Explain: _____

Migraines or severe headaches

Specify/Explain: _____

Asthma

Triggers: _____

Treatment: _____

Seizures

Frequency: _____

Bleeding Disorder

Specify/Explain: _____

Treatments: _____

Other

Behavioral/Mental Health

Anxiety

Depression

Specify/Explain: _____

Other/Explain: _____

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

Medications: _____

Treatment: _____

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 _____