STUDENT INFORMATION & ENROLLMENT FORM
Metropolitan School District of Washington Township

Today's Date: _____/_____/_____
Student ID#: _____
STN#: _____

BACKGROUND INFORMATION

Student's Legal Name: _____ _____ _____
Last *First* *Middle*

How does the student prefer to be called by teachers/friends? _____
First

Gender: ☐ Female ☐ Male **Date of Birth:** _____/_____/_____ **Age:** _____ **Grade Entering:** _____
MM DD YY

Place of Birth: _____ _____ _____
City *State* *Country*

Student's Address: _____ ____ _____ _____ _____
Address *Apt. #* *City* *State* *Zip Code*

Name of Apartment Complex or Subdivision: _____

Previous Address: _____ ____ _____ _____ _____
Address *Apt. #* *City* *State* *Zip Code*

ETHNICITY AND RACE *(NOTE: Both Part 1 and Part 2 of the question must be answered.)*

PART 1: ETHNICITY Is this individual Hispanic/Latino? (Choose only one)

☐ No, Not Hispanic/Latino ☐ Yes, Hispanic/Latino

PART 2: RACE What is the individual's race? (Choose all that apply.)

☐ American Indian or Aaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

PREVIOUS SCHOOLING

Name of Last School: _____ **School District:** _____

_____ _____ _____ _____
Address *City* *State* *Country*

1. **Has your child EVER been enrolled in any PreK-12 Indiana School (Public or Private)?** ☐ YES ☐ NO

   Most recent Indiana School:_____ Last Day Attended: _____

2. **Has your child EVER been enrolled in any PreK-12 school in Washington Township?** ☐ YES ☐ NO

   If yes, indicate most recent MSDWT School: _____ Last Day attended: _____

3. **Was your child ever retained in school?** ☐ YES ☐ NO If yes, please indicate all dates of retention:_____

4. **Was your child born outside the United States and/or is a language other than English used in your home?**

   ☐ YES ☐ NO

5. **Write the date your child initially enrolled in any K-12 school within the United States**: _____

If yes to above, please indicate the grade(s) completed: _____

FAMILY INFORMATION

FAMILY 1 ***(Parent/Legal Guardians who live at same address as student.)***

GUARDIAN 1 (Primary Contact)

_____ _____ _____
First *Last* *Relationship to Student*

_____ _____ _____
Home Phone *Cell Phone* *Work Phone*

_____ _____ _____
Email Address *Guardian's Language* *Employer*

Custodial Parent? ☐ YES ☐ NO **Can Pick Up Student?** ☐ YES ☐ NO

GUARDIAN 2

_____ _____ _____
First *Last* *Relationship to Student*

_____ _____ _____
Home Phone *Cell Phone* *Work Phone*

_____ _____ _____
Email Address *Guardian's Language* *Employer*

Custodial Parent? ☐ YES ☐ NO **Can Pick Up Student?** ☐ YES ☐ NO

FAMILY 2 ***(Parent/Legal Guardians who do NOT live at student's primary address.)***

_____ _____ _____ _____ _____
Address *Apt. #* *City* *State* *Zip Code*

GUARDIAN 1 (Primary Contact)

_____ _____ _____
First *Last* *Relationship to Student*

_____ _____ _____
Home Phone *Cell Phone* *Work Phone*

_____ _____ _____
Email Address *Guardian's Language* *Employer*

Custodial Parent? ☐ YES ☐ NO **Can Pick Up Student?** ☐ YES ☐ NO

GUARDIAN 2

_____ _____ _____
First *Last* *Relationship to Student*

_____ _____ _____
Home Phone *Cell Phone* *Work Phone*

_____ _____ _____
Email Address *Guardian's Language* *Employer*

Custodial Parent? ☐ YES ☐ NO **Can Pick Up Student?** ☐ YES ☐ NO

Does the student have siblings who are currently attending a PreK-12 school in Washington Township?

Name	*School*	*Grade*

Please share any legal restrictions regarding CUSTODY (DOCUMENTATION REQUIRED - *guardianship, restraining order, joint custody, etc.*)**:**

_____

_____

_____

EMERGENCY CONTACTS

Please list two adults other than the parent(s) or guardian(s) who may pick-up and/or care for your child in the case of an emergency:

Name: _____ _____ _____
First *Last* *Relationship to Student*

_____ _____ _____
Cell Phone *Home Phone* *Work Phone*

Name: _____ _____ _____
First *Last* *Relationship to Student*

_____ _____ _____
Cell Phone *Home Phone* *Work Phone*

ADDITIONAL CONTACT

Do you authorize any individual, in addition to the parent(s)/guardian(s), to communicate with your child's school & oversee his/her education? If so, please specify below: (MUST be over the age of 18)

Name: _____ _____ _____
First *Last* *Relationship to Student*

_____ _____ _____
Cell Phone *Home Phone* *Work Phone*

_____
Email Address

_____ _____ _____/_____/_____
Name of Parent/Guardian *Signature* *Today's Date (Month/Day/Year)*

SPECIAL CONSIDERATIONS

Did your child receive any of the following special services at his/her previous school?

☐ Special Education Services (please explain): _____ ☐ English as a New Language Services

☐ Speech/Language Therapy ☐ Occupational/Physical Therapy ☐ 504 Plan ☐ High Ability ☐ 21st Century Scholars

1. Is your child a foreign exchange student? No
2. Is your child a refugee? No
3. Does your child have a parent/guardian that is an active duty member of the armed forces? No
4. In the past 36 months, has your child moved across school district, county, or Indiana state lines in order for his/her guardian to obtain seasonal or temporary employment in the agricultural, dairy, or fishing industries **OR** out of economic necessity? No
5. If "Yes", when was the last time you or anyone in your household moved to look for work in an agricultural activity within the United States?
   Date (Month/Year): _____/_____

PERMISSIONS

TRANSPORTATION, FIELD TRIP, AND MEDIA PERMISSIONS

YES	NO	
☐	☐	I have discussed the bus rules with my child. I understand that violations of the rules will result in disciplinary consequences.
☐	☐	I give permission for my child to participate on field trips for this school year. I understand the information supplied and agree to inform the classroom teacher in the event that my child is <u>not</u> to participate in the specific field trip.
☐	☐	I give permission for my student's name or picture to be used for media release.

Name of Parent/Guardian *Signature* *Today's Date (Month/Day/Year)*

MEDICAL INFORMATION

Doctor/Physician: _____ Phone Number: _____ Address: _____

Dentist: _____ Phone Number: _____ Address: _____

_____

Preferred Hospital: _____

LIFE-THREATENING ALLERGIES/SERIOUS MEDICAL CONDITION(S)

Your child cannot start his/her first day of school until a medical alert conference is held.
This meeting will be scheduled as soon as possible, and no later than three (3) school days after the day of registration.

YES	NO	
☐	☐	**My child has a life-threatening allergy.**
		Please specify: _____
☐	☐	**My child has a serious medical condition.**
		Please specify: _____

_____ _____ _____/_____/_____

Name of Parent/Guardian *Signature* *Today's Date (Month/Day/Year)*

MEDICAL HISTORY: *In order for us to assist your child in gaining the most from his/her school experience, it is necessary to have a current health history.*

HAS YOUR CHILD EVER HAD, OR DOES HE/SHE NOW HAVE:	YES	NO	DESCRIPTION
Allergies			
- **Food**			
- **Medication**			
- **Bee sting**			
- **Other**			
Injuries – Concussion – Head Injury			
Frequent or Excessive Nose Bleeds			
Hospitalizations - Operations			
Orthopedic – Bone or Joint Problems			
Asthma			
Diabetes			
Sickle Cell Anemia			
Anemia			
Hearing Loss – Use of Hearing Aids			
Vision Loss – Wears Contacts/Glasses			
Speech Condition			
Dizziness, Fainting, Severe or Frequent Headaches			
Seizures/Convulsions/Epilepsy			
Heart Conditions			
Contact with Tuberculosis/A Positive Tuberculin Skin Test			
Severe Abdominal Pain – Ulcer			
Excessive Ear Infections			
Excessive Colds			
Frequent or Painful Urination			
Intestinal Condition			
Family History of Scoliosis			
Excessive Worry, Anxiety, or Depression			

PLEASE LIST ANY MEDICATION(S) YOUR CHILD TAKES REGULARLY:			

ANY OTHER INFORMATION THAT MIGHT BE HELPFUL FOR US TO KNOW ABOUT YOUR CHILD, OR CIRCUMSTANCES AT HOME, THAT COULD AFFECT HIM/HER AT SCHOOL?

_____

_____

HEALTH CONSENT

I hereby give consent for my minor child to receive necessary health services from the designated Health personnel or other designated District personnel in our schools when he/she becomes ill or injured during the school day. I understand that treatment by District or Health personnel is limited to first aid care for injuries occurring at school, illness, or health screens in conjunction with the Marion County Health Department and the administration of previously authorized medication. I understand that injuries incurred elsewhere, other than at school, must be cared for at home or by a personal health care provider.

I hereby give permission for the above information to be shared with appropriate staff and emergency personnel in a confidential manner under the provisions of the Family Education Rights and Privacy Act (FERPA). I understand that FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances.

I hereby authorize the MSD of Washington Township to release my child's immunization record to the Indiana State Department of Health's Children and Hoosier Immunization Registry Program (CHIRP). I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my eligible child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

_____ _____ _____/_____/_____

Name of Parent/Guardian *Signature* *Today's Date (Month/Day/Year)*