Fortine School District

PK-8 NEW STUDENT ENROLLMENT FORM

OFFICE USE ONLY	Student State ID:	Birth Certificate: □Yes □No	Immunizations Received: □Yes □No	School Entry Date:

STUDENT INFORMATION

(Legal Name Only) Last name	First	Middle	Suffix(Jr., II, III)
Preferred Name:		Nickname:	

Grade:	Date of Birth: / /	Birth Place (City, State)	Gender: □ Male □ Female	Is student a US citizen? □ Yes □ No

Mailing Address:		
City:	State:	ZIP Code:
Physical Address:		
City:	State:	ZIP Code:

Previous enrolled in a Montana School: □ Yes If Yes: Date: _____ Grade: _____ □ No School: Address:	Is student Hispanic or Latino? □ Yes □ No Primary phone: ( ) -	Race (Select one or more): □ White □Native Hawaiian or Other Pacific Islander □ Black or African American □ Asian □ American Indian or Alaska Native
Medical Concerns/Allergies:		

PARENT AND EMERGENCY CONTACT INFORMATION

PARENT/GUARDIAN

□ Lives with student

□Student's legal Guardian

□Mailing List

Last Name:	First Name:		
Relation to Student:	Email Address:		
Place of Employment:			
Home Address: (if different than Students)	City:	State:	Zip Code:
Mailing Address: (if different than home address)	City:	State	Zip Code
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Other: ( )

PARENT/GUARDIAN OTHER

□ Lives with student

□Student's legal Guardian

□Mailing List

Last Name:	First Name:		
Relation to Student:	Email Address:		
Place of Employment:			
Home Address: (if different than Students)	City:	State:	Zip Code:
Mailing Address: (if different than home address)	City:	State	Zip Code
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Other: ( )

Emergency Contact (other than parent/Guardian

Last Name:		First Name:	
Relation To Student:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Home Address:	City:	State:	Zip Code:

Additional Contact

Last Name:		First Name:	
Relation To Student:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Home Address:	City:	State:	Zip Code:

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SIBLINGS

Complete this section only if applicable. Please include siblings who are currently in Fortine School.

Sibling #1 Full Name:	Grade:
Sibling #2 Full Name:	Grade:
Sibling #3 Full Name:	Grade:
Sibling #4 Full Name:	Grade:
Sibling #5 Full Name:	Grade:
Sibling #6 Full Name:	Grade:

PREVIOUS SCHOOL(S)

	Name Of School	City	State	Grade
Last Elementary School Attended				
Last Middle School Attended				
Any Additional Schools Attended In The Past Year				

QUESTIONS FOR PARENTS

Has your student ever received service from or been involved in (check all that apply):

□ Special Education □ Title I □Speech therapy □Section 504

□Behavior Management □ Counseling □Gifted Program

□ Other (explain):

Has this student ever been under long term suspension or been suspended from school? □ Yes □ No

Legal Bindings: Please list any legal binding information, including restraining orders, custody agreements that are pertinent to this student and his/her safety (copy of the legal documentation is required).	**Is there any other information that would help us better serve your student?**

Health And Medical Information

□ **Allergies to:** □ Bee Sting □Food □Environment □Latex □Medication □Other

Name(s) of Medication(s): _____

□ *needs medication at School □takes medication at home

Describe reaction and intervention: _____

List other allergies:

□ **Asthma:**
Name of medication(s) _____
□ *needs medication at School □ Takes medication at home □ carries inhaler on person □ inhaler in school office

□ **Attention Deficit Disorder:**
Name of Medication(s) _____
□ *needs medication at School □ takes medication at home □ diagnosed but takes no medication

□ **Diabetes:** □ *Insulin dependent/needs school program set up □ * Self manages snacks, diet, testing, coverage

□ **Headaches:** Name of medication(s):

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□	**Seizures:** Name of medication(s): _____ □ *needs medication at School □ takes medication at home □ history of seizure but not currently on medication
□	**Other Medications:** **Diagnosis:** _____ Name of medication (s): _____ □ * needs medication at School □ takes medication at home □
□	**Hearing Concerns: Please explain.**
□	**Vision Concerns: Please explain.**
□	**Physical Restrictions:** □ Uses mobility aide (wheelchair, walker, crutches, etc.) □ Restricted because of _____ □ Must avoid this/these activities _____

□ **I have completed the emergency form sign off. This form can be obtained from the district clerk.**

***NOTE:** If medication is needed, the parent/guardian must complete a medication authorization form before the first dose of medication can be given at school. The health concern information may be shared with school personnel as necessary to benefit the health and safety of this student and others. Please keep school staff informed as to changes to the information so the student's records can be updated as needed. All medication will be kept in a secure location in the school.

All information provided above is complete and accurate the best of my knowledge.

Signature of Parent/Guardian: Date: