Student Enrollment Form

Date:_____ **School:** _____

Student Name:_____
First Full Middle (required) Last

Physical Address:_____

Mailing Address (if different from physical): _____

Home Phone # _____ **DOB**: _____ **Birthplace:**_____ **Sex**: ____ **Grade**: _____

Federal Ethnicity and Race:

Ethnicity Is the student Hispanic or Latino? ( ) Yes ( ) No

Race What is the student's race? □ (I) American Indian or Alaska Native, □ (A) Asian, □ (B) Black or African American, □ (P) Native Hawaiian/Other Pacific Islander, □ (W) White

Is your child on a special education plan (IEP)? _____
Is your child on a 504 plan? _____
Does your child receive Title 1 services? _____
Has your child previously attended another SAU 29 school? (Keene, Chesterfield, Harrisville, Marlborough, Marlow, Nelson, Westmoreland) (If yes, please state which school) _____

Child Lives With: (check all that apply)

_____	Mother and Father	_____	Mother, Stepfather	_____	Guardian
_____	Mother	_____	Father, Stepmother	_____	Grandparent(s)
_____	Father	_____	Foster Home	_____	Other (please specify)

If applicable, please provide copies of the following Court documents: Divorce decree, parenting plan, physical and legal custodial arrangements, guardianship, restraining orders.

Unless otherwise stated, the order of contact will be as follows:

Father/Legal Guardian	**Mother/Legal Guardian**
Name:	Name:
Mailing Address:	Mailing Address:
Home Phone:	Home Phone:
Day Phone:	Day Phone:
Cell Phone:	Cell phone:
Place of Employment:	Place of Employment:
E-Mail Address:	E-Mail Address:

Emergency Contact #1	**Emergency Contact #2**
Name:	Name:
Relationship to Child:	Relationship to Child:
Home Phone:	Home Phone:
Day Phone:	Day Phone:
Cell Phone:	Cell phone:

Emergency Contact #3	**Emergency Contact #4**
Name:	Name:
Relationship to Child:	Relationship to Child:
Home Phone:	Home Phone:
Day Phone:	Day Phone:
Cell Phone:	Cell phone:

Childcare Provider (if applicable)

AM	PM
Name	Name
Address	Address
Phone #	Phone #

Transportation

Morning	Afternoon
Bus	Bus
Van (specify)	Van (specify)
Parent drop off	Parent pick up
Walker	Walker

Siblings

Name	Date of Birth	School Attending

Will you have a child entering Kindergarten next fall? Yes___ No___

If yes, Name: _____ DOB _____ (Must be 5 by September 30th)

Previous Experiences of Child:

Preschool:	Days/Wk:	Years Attended:
Day Care:	Days/Wk:	Years Attended:
Other:	Days/Wk:	Years Attended:

Other Schools Attended:

Name:	Location:	Phone #	Years Attended:
Name:	Location:	Phone #	Years Attended:
Name:	Location:	Phone #	Years Attended:

Health Conditions which may require school's attention (i.e., poor hearing, allergies, diabetes, epilepsy, etc.):

_____

Family Physician:

_____

Name Address Phone #

Health Insurance Information:

Insurance Company Name:_____

The following information will help us give your child appropriate care and attention at school.

How does your child feel about entering school?_____

Physical Development

1. Did you have an illness during your pregnancy? Yes No

2. Was the child born at full term? (9 months) Yes No

Birth weight? _____

Any other information concerning your child's birth: _____

_____

3. Circle any of the following diseases that the child's parents, grandparents, brothers, sisters have had: heart disease, tuberculosis, diabetes, asthma, allergy, seizures, cancer, mental illness (family history of diseases helps in understanding your child's health).

4. Has your child had any pre-school illnesses such as: operations, serious injuries, chicken pox, rheumatic fever, kidney condition, etc.? Yes No

If yes, please list:

_____

5. **Development**

Has your child received any early intervention services? Yes No
At what age did your child first start using words? _____
Is your child's speech easily understandable? Yes No
Does your child have difficulty following simple directions? Yes No
Does your child hesitate and/or repeat sounds or words? Yes No

Do you have any concerns regarding your child's speech? Yes No
Does your child have behavior problems? Yes No
Does your child learn new tasks easily? Yes No

Comments:_____

_____

6. Does your child have any hearing difficulties? Yes No
7. Does your child have earaches? Yes No
8. Does your child have any eye problems? Yes No
9. Does your child eat breakfast? Yes No
10. Does your child have any toilet problems? Yes No
11. Has your child ever had a convulsion? Yes No
12. Does your child have allergies? Yes No
    If yes, to what?_____
13. Which hand does your child prefer using? _____

14. **Sleep Habits**

Does your child take a long time getting to sleep? Yes No
Does your child have nightmares? Frequently _____ Occasionally _____
Does your child wet the bed? Frequently _____ Occasionally _____
Does your child take a nap? Frequently _____ Occasionally _____
Does your child appear to tire in the afternoon? Yes No
What kind of help does your child need at bedtime and in the morning with undressing, dressing, and toileting?
_____

Social Development

1. With whom does your child play most of the time (please include ages)?_____
_____

2. How well does your child get along with other children?_____

3. What kinds of play activity does your child prefer?_____

4. How active is your child? _____

5. Can your child focus on an activity for a period of time?_____

6. Have you found your child "easy to get along with", "hard to handle", etc.?_____

7. Which of the following has your child experienced? Please check all that apply.
Moving _____ How many times_____ Where from_____
Living with someone other than parent_____
A great fright _____ A death in the family_____
A parent away from home for an extended period of time _____

Any other significant experience in your child's life? _____

_____

Was there any significant change in behavior following any of the above events?_____

_____

How would you describe your child?_____

_____

How do you feel about your child's entrance into school?_____

_____

Public Law 200:32 Medical Examination of Students: There should be a complete medical examination by a licensed physician of each child prior to or upon first entry into the public school system and thereafter as often as deemed necessary by the local school authority.

_____

Under penalty of perjury I declare that I am the mother – father – legal guardian (circle one) of _____ (student's name) and reside at _____.

With whom does the child live? (List name and relationship): _____

Describe custodial arrangement (if applicable, and attach documentation): _____

The answer you give below will help the district determine services your child may be able to receive under the McKinney-Vento Act created to protect homeless students.

Where is the student currently living? Please check **only one**.

_____1. In permanent housing (apartment, house – own or rent)
_____2. In a shelter
_____3. With another family member or other person (sometimes referred to as "doubled up")
_____4. In a hotel/motel
_____5. In a car, park, bus, train, or campsite
_____6. Other temporary living situation (please describe) _____

If you checked yes to 2-6, please provide us with your former address:

_____

I swear that the above information is true and accurate. In accordance with RSA 641:3, the School District may choose to initiate legal proceedings against any person who provides misleading or untrue information, or who omits information necessary to prevent statements herein from being misleeading, in the completion of this form.

_____ _____
Print Name of Parent or Legal Guardian Signature of Parent or Legal Guardian

Date: _____

Home Language Survey

School**:**_____ District**:**_____ Date:_____

Student Information			
First name:	Last name:	Date of Birth:	Gender: ☐ female ☐ male
Country of Birth:		Date first enrolled in a U.S. school: Month_____ Year_____	Current grade:

Family Information	
Name of parent/legal guardian:	Phone number:
Address:	☐ Please translate school notices. Language_____

Questions for Parents/Guardians	**Response**
Please list all languages spoken in your home.	
Which language did your child first hear or speak?	
If English is the only language listed, stop here. If another language is listed, please answer the rest of the questions.	
Which language(s) do you speak to your child?	
Which language(s) does your child speak at home with adults?	
Which language(s) does your child speak at home with other children?	

For parents and guardians: If a language other than English is listed above, an ESOL teacher will test your child to find out if he or she can speak, understand, read, and write well in English. The results will be sent to you within 30 days. Based on the results of the test, your child may be eligible to enroll in an English language (ESOL) class at school. Parents/guardians may accept or decline ESOL program services for their child.

Instructions for survey administrator:
1. Please provide an interpreter when necessary.
2. If responses indicate a language other than English, please contact the ESOL teacher and provide her/him with a copy of this survey. Date of referral to ESOL teacher: _____
3. File original Home Language Survey in student's cumulative folder.

Student Name: _____

School Nurse Record

Welcome to school! Your school nurse would like to get to know your child and help promote their good health. Please answer the following questions for your child's school health record.

1. Does your child wear glasses? Yes ___ No ____
   If yes, at what times? _____
   If yes, who is your child's eye doctor? _____

2. Does your child have any health issues the nurse should be aware of? Yes ___ No ____
   If yes, please list:_____
   _____

3. Does your child take any daily medication? Yes ___ No ____
   If yes, what is its name, dose and frequency?
   _____

4. Has your child had chicken pox? Yes ___ No ___
   If yes, what month and year? _____

5. Does your child have medication allergies? Yes ___ No ___
   If yes, please list: _____

6. Does your child have any environmental allergies? Yes ___ No ___
   If yes, please list: _____

7. Does your child have food or dietary restrictions? Yes ___ No ___
   If yes, please list: _____

8. Does your child have health insurance? Yes ___ No ___
   If yes, what is the name?_____

9. What is the date of your child's last physical exam, or pending appointment date?
   _____

10. Any other concerns? _____
    _____

Please continue to keep us informed of any changes in your child's health status, medication or immunization dates.

_____ _____

Parent/Guardian Signature Date