

**WASHINGTON WEST SUPERVISORY UNION
STUDENT ENROLLMENT INFORMATION, HEALTH & EMERGENCY FORM**

For Office Use Only:

TA/Home Room: _____ Counselor: _____
Student ID: _____ Birth Certificate Checked: _____

Person or Agency Completing Form: _____

Entering School: _____ Entering Grade: _____

Student: _____
Last First Middle

Nickname: _____ Date of Birth: _____ Place of Birth: _____

Gender: _____ Family last name: _____ Language Spoken: _____

Languages (other than English) spoken in home: _____

What language did child learn first: _____ If applicable, when did student arrive in US: _____

Native Language of Each Parent/Guardian: _____

Ethnicity (circle those that apply): White American Indian/Alaskan Native Asian Hispanic/Latino
Black/African American Native Hawaiian/Other Pacific Islander

Primary Mailing Address: _____

Primary Physical (E-911) Address: _____

Town of Legal Residence: _____

Primary Home Phone: _____ Primary E-mail: _____

Secondary E-mail: _____ Student's School/Personal E-mail: _____
(Be advised that the email addresses provided above will be added to the CBMS parent email lists, which will be used for school purposes only, and will not be shared with any outside organizations.)

Secondary Mailing Address (if applicable): _____

Previous school(s) or preschool programs attended (name, address, grade(s), dates):

PARENT/GUARDIAN INFORMATION

Parent #1 Name: (First, Last) _____

Address (if different from primary address): _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Employer: _____

Parent #2 Name: (First, Last) _____

Address (if different from primary address): _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Employer: _____

Step-parents' Names: (first, last) _____

List other children in the home (oldest to youngest):

<u>Name</u>	<u>Date of Birth</u>	<u>Grade</u>	<u>Residence</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If there are additional children, please attach a separate sheet.

List other adults living in the home:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

If there are additional adults, please attach a separate sheet.

Custody:

Custody/Guardianship (mother, father, joint, other) _____. If legal guardian is someone other than the parent(s), please provide name and address, and contact information:

If student is in custody of a state agency (e.g. DCF), DCF worker has to enroll the student and include SPS enrollment form. Send copy of the SPS form to WWSU Director of Student Services.

If changes occur in your family unit, notify the school promptly and provide the legal documentation needed in order to abide by those changes. School administrators must receive documentation of any special custodial requirements in order to abide by them. A copy of any Court Order pertaining to custody, restrictions or visitation of the child you are enrolling must be given to the school; otherwise, each parent has equal rights. If this student does NOT live with both biological parents, or guardian, please review and check the following, if applicable.

- ___ There is currently no written stipulation or court order pertaining to the custody and care of my child.
- ___ There is a written stipulation or court order pertaining to the custody and care of my child (**attach a copy of written stipulation or court order to this application**).
- ___ There are people who are legally forbidden from having contact with this child.
Names: _____

(Attach copy of restraining order, divorce decree, etc. as documentation)

- ___ My child lives in a developmental home in the WWSU. (needs SPS enrollment form)
- ___ Student is living in a foster home. (needs SPS enrollment form)

Emergency Contact Information (if parent cannot be reached):

Emergency Contact #1: _____

Phone: _____ Relationship: _____

Emergency Contact #2: _____

Phone: _____ Relationship: _____

Medical Information:

Doctor's Name: _____ Date of Last Physical Exam: _____
(due once a year)

Dentist's Name: _____ Date of Last Dental Exam: _____

Eye Doctor's Name: _____ Date of Last Eye Exam: _____

Please read each item, check area if it relates to your child, and comment below:

- ___ Accident
- ___ Allergy (if checked, what is child's reaction?)
- ___ Skin problems (e.g. rashes)
- ___ Recurrent colds, congestion
- ___ Specific oral issues
- ___ Hospitalizations
- ___ Chicken pox disease Date: _____
- ___ Bladder problems
- ___ Respiratory (breathing issues, e.g. asthma) If yes, does the child use an inhaler? How often? For sports only?
- ___ Vision problems
- ___ Ear infections/hearing loss
- ___ Epilepsy (seizures)
- ___ Developmental delay (any area)
- ___ Other medical concerns (heart defect, diabetes)
- ___ Lead poisoning
- ___ Bowel problems

Comments: _____

Immunization Record Received: _____ (VT Immunization Law states we must have a copy of the immunization record)

Please check the appropriate box:

- Yes No Was your child born premature?
 Yes No Were there any birth complications? If yes, explain below.
 Yes No Do you think your child's development is progressing well?
 Yes No Is your child on any medications on a regular basis? If yes, explain below.
 Yes No Is there any significant family health history? (e.g. epilepsy, diabetes, heart disease)

Comments: _____

Are there any limitations on your child's activities in school? Yes No
If yes, please explain: _____

Has your child received any assistance for:

- | | | |
|--|----------------|-------------|
| <input type="checkbox"/> Speech | By whom: _____ | When: _____ |
| <input type="checkbox"/> Learning disabilities | By whom: _____ | When: _____ |
| <input type="checkbox"/> Reading | By whom: _____ | When: _____ |
| <input type="checkbox"/> Mathematics | By whom: _____ | When: _____ |
| <input type="checkbox"/> Counseling | By whom: _____ | When: _____ |

My child has permission to take the following non-prescription medication at school under the supervision and judgment of the school nurse:

- Tylenol/acetaminophen Advil/ibuprofen Benadryl Cough drops
 Other: _____

Reason for administration: _____

*If medication other than Tylenol, Advil, Benadryl, or cough drops needs to be given at school, please review medication procedures and complete the Medication Order and Permission Form.

If you do not want your child to receive medications, please check the statement below:

- No medications are to be given to my child without calling me first.

Does your child take prescription medication? ___Yes ___No
If yes, why and what is the medication? Does the medication need to be taken at school?

It is preferable to arrange for students to take any medications at home whenever possible. If medicines must be taken during school hours, school policy requires that they be sent to school in the original pharmacy container, with a doctor's order and a written parent request. Please arrange to have an adult bring the medication to the health office. For safety reasons, students are NOT allowed to carry medication with them on the bus or at school.

Do you have health insurance for your child? ___Yes ___No

If yes, please state: Provider: _____ Subscriber: _____
Policy Number: _____

If no, call 1-800-250-VHAP for more information.

Do you have dental insurance for your child? ___Yes ___No

If yes, please state: Provider: _____ Subscriber: _____
Policy Number: _____

Would you like information about Green Mountain Core (benefits of this insurance include prescriptions, eye care, dental care, and mental health care)? ___Yes ___No

___Yes ___No I hereby grant permission to the School Nurse and/or Administrator to request or share pertinent information related to my child's health and well-being with other school personnel or medical/dental providers as necessary.

Academic/Social/Emotional Information

Please describe in detail any distinguishing characteristics your child may have, such as fears, temper, extreme likes or dislikes, shyness, etc. This will help the school assist with your child's adjustment to the many new experiences ahead.

Describe your child's strengths and needs (academic, social, emotional).

Consent for Emergency Treatment:

In case my child has a serious accident or sudden serious illness, I request the school to contact me. If not able to reach me, I authorize school personnel to seek emergency medical care, including transportation (at my expense) to a health care facility. I authorize the physician in charge to administer whatever emergency treatment is necessary at my expense.

Parent/Guardian Signature

Date

Consent for Field Trips:

I give permission for my child to go on school field trips. My child will be transported by bus. I will be notified in advance of all pending trips. My child may also go on walking trips with a teacher within a reasonable distance of the school.

Parent/Guardian Signature

Date

IF ANY INFORMATION PROVIDED HEREIN CHANGES OVER THE COURSE OF THE SCHOOL YEAR, PLEASE ADVISE BY CALLING _____ AT _____ . THANK YOU.

Name/Signature of person registering student (must be a legal guardian):

Printed Name

Signature

Date