

# Winslow USD#1 – Student Registration Form

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School: \_\_\_\_\_ School ID#: \_\_\_\_\_ SAIS ID#: \_\_\_\_\_  
 Enrollment Code: \_\_\_\_\_ Enrollment Date: \_\_\_\_\_ Date Entered in Powerschool: \_\_\_\_\_

**STUDENT INFORMATION (Please Print)**

Student's Last Name		First Name		Middle Name	
Date of Birth	Place of Birth (City, State, Country)			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Grade
Primary Home Address			City	State	Zip Code
2 <sup>nd</sup> Home Address (if applicable):			City	State	Zip Code
Primary Mailing Address (if different from home address listed above)			City	State	Zip Code
2 <sup>nd</sup> Mailing Address (if applicable)			City	State	Zip Code
Primary Phone Number	Dorm Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	With whom does student reside? <input type="checkbox"/> Father <input type="checkbox"/> Step Father <input type="checkbox"/> Mother <input type="checkbox"/> Step Mother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Guardian <input type="checkbox"/> Other (Specify): _____			Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Am. Indian/Alaskan Native Tribe: _____
Student Cell: (gr 7-12 only)					

**SUPPORT SERVICES**

Does your child require or has he/she ever received special help/services for any or the following (Check those that apply):  
 Specific Learning Disability (SLD)  Other Health Impairment (OHI)  Orthopedic Impairment (OI)  Mental Retardation  Emotional Disability  
 Traumatic Brain Injury  Visual Impairment (VI)  Hearing Impairment (HI)  Multiple Disabilities  Speech/Language Impairment  Autism  
 Physical handicap  Preschool Delays  Gifted  Other (specify): \_\_\_\_\_

**PARENT/GUARDIAN EMPLOYMENT STATUS/INFORMATION:**

Provide complete employment information for the parents/guardians with whom the student resides.

FATHER  MOTHER  OTHER:

Parent/Guardian's Last Name	First Name and M.I.	Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Active Duty Uniformed Services: Branch of Service: _____ Rank: _____	Work/Daytime Phone Number/Ext.
Business Name of Employer		E-mail	Cell Phone Number

FATHER  MOTHER  OTHER:

Parent/Guardian's Last Name	First Name and M.I.	Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Active Duty Uniformed Services: Branch of Service: _____ Rank: _____	Work/Daytime Phone Number/Ext.
Business Name of Employer		E-mail	Cell Phone Number

FATHER  MOTHER  OTHER:

Parent/Guardian's Last Name	First Name and M.I.	Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Active Duty Uniformed Services: Branch of Service: _____ Rank: _____	Work/Daytime Phone Number/Ext.
Business Name of Employer		E-mail	Cell Phone Number

**For Native American Students Only**

Tribal Name (e.g. Navajo, Hopi, Apache, etc.)	CIB # / Blood Quantum	Certificate on File: <input type="checkbox"/> Yes <input type="checkbox"/> No	506 Form on file: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of 506:
Chapter House/Village/Pueblo Affiliation:		Physical Address of Home on Indian Lands (if not listed above):		

The information requested on this form may be provided to the U.S. Department of Education if the school district's Impact Aid application for payment is audited. This form must be signed and dated for your school district to receive funds based on this information.

→ Signature of Parent/Guardian: \_\_\_\_\_ → Date: \_\_\_\_\_ WPS 601 (9-14)

# Winslow USD#1 - Student Registration Form

# B

### STUDENT INFORMATION (Please Print)

Student's Last Name	First Name	Middle Name	Grade
Name and Address of Last School Attended		Number of years at this school	Number of years in Winslow Schools

### ENROLLMENT ELIGIBILITY STATUS AT LAST SCHOOL ATTENDED

Is student on long-term suspension from last school attended?  Yes  No  
 If yes, date of long-term suspension: \_\_\_\_\_ Length of suspension: \_\_\_\_\_

Was student expelled from last school attended?  Yes  No  
 If yes, date of expulsion: \_\_\_\_\_

### WHO IS NOT ALLOWED TO SEE OR PICK UP THIS STUDENT?

A court order must be on file at the school office if one/both of the child's parent(s)/guardian(s) are listed below.

Name(s)	Date of Court Order	Relationship to child
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### STUDENT RELEASE INFORMATION

Who, besides parent/guardian, is allowed to pick up student? I UNDERSTAND THAT ONLY THE PEOPLE LISTED BELOW WILL BE AUTHORIZED TO SIGN MY CHILD OUT. The school will require proper identification of the persons listed below and they must be 18 years of age or over.

Name	Phone #	Relationship to Student

### HOME LANGUAGE:

What is the primary language used in the home regardless of the language spoken by the student? \_\_\_\_\_

What is the language most often spoken by the student? \_\_\_\_\_

What is the language that the student first acquired? \_\_\_\_\_

### DIRECTORY INFORMATION: Please check the desired response below:

Permission to publish your child's information (student work; photos of student for projects in class; child's picture and name in the paper or radio)  Yes  No

### STUDENT TRANSPORTATION INFORMATION: Place check on the desired response line below:

Bus Rider  Yes  No  
 Walker  Yes  No  
 Parent/Guardian Transports  Yes  No  
 Other: (Specify) \_\_\_\_\_

### PLEASE LIST ALL CHILDREN LIVING IN THE HOME WHO ARE 18 YEARS OR YOUNGER BY NAME AND AGE:

Name	Age	Name	Age

→ Signature of Parent/Guardian: \_\_\_\_\_ → Date \_\_\_\_\_ WPS 602 (3-15)

HEALTH INFORMATION

TO BE COMPLETED BY PARENT OR GUARDIAN EACH SCHOOL YEAR

Student's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

My child has a medical condition that may affect his or her school day € NO € YES

€ ALLERGIES Additional form required

€ Food List food(s) \_\_\_\_\_

€ Medication List medicine(s) \_\_\_\_\_

€ Bee sting \_\_\_\_\_ € Other \_\_\_\_\_

Reactions

€ Coughing € Hives € Rash € Difficulty breathing € Local swelling € Wheezing

€ Generalized swelling € Nausea € Other \_\_\_\_\_

Currently prescribe treatments to be used IN SCHOOL

€ Oral antihistamine (Benadryl, etc.) € EpiPen € Other

€ ASTHMA

Triggers € Exercise € Environmental € Other (list) \_\_\_\_\_

Physical Education restrictions € None € Self limits € Other \_\_\_\_\_

Symptoms or reactions

€ Chest tightness, discomfort, or pain € Difficulty breathing € Throat itch, tightness, or soreness

€ Coughing € Hoarseness € Wheezing € Other \_\_\_\_\_

Currently prescribe treatments to be used IN SCHOOL

€ Inhalers € Oral antihistamines € Oral steroids

€ Nebulizer € Oral Bronchodilator € Peak flow monitoring

Date of last hospitalization related to asthma \_\_\_\_\_

€ DIABETES

Currently prescribe treatments to be used IN SCHOOL

€ Insulin € Syringe € Pen € Pump € Blood sugar testing € Glucagon € Oral medication(s) List medication(s) \_\_\_\_\_

Is special scheduling of lunch or Physical Education required? € NO € YES

€ SEIZURE DISORDER

Type of seizure: € Absence (staring, unresponsive) € Complex partial € Generalized tonic-clonic (grand mal, convulsive) € Other (explain) \_\_\_\_\_

Physical Education restrictions: € NO € YES \_\_\_\_\_

Medications needed IN SCHOOL € NO € YES List medication(s) \_\_\_\_\_

Date of last seizure \_\_\_\_\_ Length of seizure \_\_\_\_\_

€ OTHER HEALTH CONDITIONS

€ Cancer € Heart condition (be specific) \_\_\_\_\_

€ Hemophilia € Physical disability (be specific) \_\_\_\_\_

€ Respiratory (be specific) \_\_\_\_\_

€ Other medical conditions including: Concussions, Chicken pox, Arthritis, Eczema, Fainting, Hepatitis, MRSA, Hyperactivity, Kidney trouble, Mental/emotional concerns, ADHD, ADD, Migraines, Scoliosis, TB, Whooping cough) \_\_\_\_\_

Physical Education restrictions € NO € YES \_\_\_\_\_

Medications needed IN SCHOOL € NO € YES List medication(s) \_\_\_\_\_

Special procedures (e.g. catheterization, cardiac monitor, etc) required IN SCHOOL € NO € YES (explain) \_\_\_\_\_

Medication taken at home € NO € YES List medication(s) \_\_\_\_\_

€ VISION CONDITIONS

€ Contacts € glasses € Other \_\_\_\_\_

€ HEARING CONDITION

€ Hearing aid(s) € Known hearing loss Year \_\_\_\_\_

Parent/guardian is responsible for providing the school with any medications, special food, or equipment that the student requires during the school year. Also, parents/guardian is responsible for providing the district with medical information, authorization forms, and written consent if it is necessary for the school nurse to exchange information with the student's physician.