

Student Enrollment Form

Date: _____

School: _____

Student

Name: _____

First

Middle (required)

Last

Residence Address: _____

Mailing Address (if different from residence):

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

Ethnic Code: _____ (01 American Indian/Alaska, 02 Asian American/Pacific Islander, 03 Hispanic, 04 Black but not Hispanic, 05 White and not Hispanic, or 07-63 mixed combination – please see list attached)

Is your child on a special education plan (IEP)? _____

Child Lives With: (check all that apply)

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

~~~~~  
**Mother's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Address and Phone # (if different from student):  
\_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work # \_\_\_\_\_ Occupation: \_\_\_\_\_

Hours Worked: \_\_\_\_\_ Cell Phone # \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

~~~~~  
Father's Full Name: _____ **DOB:** _____

Address and Phone # (if different from student):

Place of Employment: _____ Work # _____ Occupation: _____

Hours Worked: _____ Cell Phone # _____ E-Mail Address: _____

~~~~~  
**Stepparent's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work # \_\_\_\_\_ Occupation: \_\_\_\_\_

Hours Worked: \_\_\_\_\_ Cell Phone # \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

~~~~~  
If parents cannot be reached, please notify: (required)

Name: _____ Home # _____ Work # _____

Relationship to Child:

Name: _____ Home # _____ Work # _____

Relationship to Child:

~~~~~  
**Childcare Provider (if applicable)**

AM \_\_\_\_\_

PM \_\_\_\_\_

| Name | Address | Phone # |
|------|---------|---------|
|------|---------|---------|

**Name and Birth Dates of Siblings:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Will you have a child entering Kindergarten next fall? Yes\_\_\_ No\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_ (Must be 5 by September 30th)

~~~~~  
Previous School Experiences of Child:

Nursery School: _____ Days/Wk: _____ Years Attended: _____

Day Care: _____ Days/Wk: _____ Years Attended: _____

Head Start: _____ Days/Wk: _____ Years Attended: _____

Other elementary schools attended:

Name	Location	Phone #	Years
Attended			

Student Name: _____

Transportation:

Transported at district expense? Yes____ No____ Bus? Yes____ No____ If Yes, AM____ PM____

Special van _____ Other _____

~~~~~

**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: _____

Policy # _____

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 _____ (relationship to student) of _____ (student’s name) and reside at _____.

All of the information on this form is important for safety purposes; for state reporting purposes; and for the determination of where the student is entitled to attend school tuition free. Under penalty of unsworn certification - see RSA 641:3 - I/We declare that the information on this form is correct. I/We will promptly notify the principal of the school of any change in the information on this form.

Signature of mother, father or guardian

Questionnaire completed by: _____

 Signature

 Relationship to Child

Student Name: _____

Home Language Survey

Is a language other than English spoken in your home? Yes _____ No _____

If you answered no to this question, please proceed to page 6.

If you answered yes to this question, please complete the following:

1. What language did your child first learn to speak? _____
2. What language do you most often use when speaking to your child? _____
3. What language does your child most often use when speaking to adults in the home? _____
4. What language does your child most often use when speaking with children at home? _____
5. What language does your child most often use when speaking with friends? _____
6. Has your child studied the English language in school? _____
If yes, which grades? _____
7. Has your child learned school subjects in English? _____
If yes, what grades? _____
8. Has your child learned school subjects in another language? _____
If yes, what language? _____ What grade? _____

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 and policy #? _____

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