

Niles City School District: Student Enrollment Form

Copies of the following documents are required upon enrollment: birth certificate, social security card, immunization records, proof of residency and custody papers

FOR OFFICE USE ONLY			
Entry Date ____/____/____	Building _____	Grade _____	Homeroom _____ ESIS ID _____
List Proof of Residency _____ <i>(Utility bill, rent receipt, mortgage agreement, etc)</i>	Custody papers on file? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable		
Ethnicity: H W B A I P M			

Demographic Information

Student's Name _____ Preferred first name _____
(Legal First Name) (Middle Name) (Legal Last Name)

Student's Address _____ Apt. # _____ P.O. Box _____
(Street)

(City) (State) (Zip) County _____

Home Phone: _____ Unlisted Cell Phone: _____

Birth date: ____/____/____ Birthplace: _____
(Month) (Day) (Year) (City) (State)

Social Security # _____ - _____ - _____ Male Female

Is English your child's first language: Yes No

If not, what is your child's first language: _____

Parental /Guardian Information

Natural Father _____ Deceased Place of Employment _____

Residential Address: Street _____ City _____ State _____

Phone (Home) _____ (Cell) _____ (Work) _____

Natural Mother _____ Deceased Place of Employment _____

Residential Address: Street _____ City _____ State _____

Phone (Home) _____ (Cell) _____ (Work) _____

Parents are: Married Divorced Separated Never Married

COPY OF THE COURT DOCUMENT AWARDING CUSTODY WITH A JUDGE'S SIGNATURE IS REQUIRED.

If parents are divorced or separated, complete the following:

Name of Custodial Parent _____ Has the custodial parent remarried? Yes No

If so, name of step-parent _____

Does non-residential or non-custodial parent want copies of school correspondence? Yes No

If student is not living with either natural parent, complete the following:

Name of person the student is living with _____ Relationship _____

Was placement made by Court Order? Yes No Case # _____

Placing Agency _____ Phone: _____ Caseworker _____

Niles City School District: Student Enrollment Form.

<u>Brothers/Sisters</u> (list first/last name) _____	<u>Age</u>	<u>Grade</u>	<u>School</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Student Information

Mark problems your child may have that are related to health and/or school.

Eyesight Hearing Speech Heart Abnormal Fears Diabetes
 Allergies (list): _____ Life-Threatening? Yes No Other _____

Does your child have a 504 plan? Yes No If yes, do you have a copy? Yes No

Does your child have a current Individualized Education Plan (IEP)? Yes No

If no, was your child in the process of a multi-factored evaluation? Yes No

If yes, do you have a copy of the multi-factored evaluation? Yes No

If your child has an IEP, what is your child's disability? _____

Has your child received any other services? (Title I, Reading Recovery, Speech, Physical Therapy, etc.)

Please list services currently receiving: _____

Previous School

Name of Last School Attended _____

Address: Street _____ City _____ State _____

Did your child previously attend Niles City Schools? Yes No School _____ Yr. _____

List previous Headstart, day care or pre-school (Gr. K/1 enrollment only) _____

Open Enrollment Applicants:

Name of home school district _____

Have you enrolled in your home school district? Yes No

Have you completed an Open Enrollment application to Niles City Schools? Yes No

Signature

I verify that all information above is accurate and that my child fulfills all the requirements for attending the Niles City School District.

(Parent/Legal Guardian signature)

(Date)

NILES CITY SCHOOL DISTRICT ETHNICITY QUESTIONNAIRE

Student Name _____

Birth Date ____/____/____

Per United States Department of Education requirements, when collecting race/ethnicity information districts must collect this information by using a two part question found below.

Part 1: ETHNICITY

Is the student **Hispanic/Latino** (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race) ____ **Yes** ____ **No**

Regardless of whether your answer is Yes or No to Part 1, you must also select 1 or more racial groups in Part 2.

Part 2: RACIAL GROUP

Is the student from one or more of the following racial groups (check all that apply):

____ **(W) White**

People who have origins in any of the original peoples of Europe, North Africa, or the Middle East.

____ **(B) Black or African American**

Persons having origins in any of the black racial groups in Africa.

____ **(A) Asian**

Persons having origins in any of the original peoples of the Far East, Southeast Asia, or The Indian subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

____ **(I) American Indian or Alaskan Native**

Persons having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.

____ **(P) Native Hawaiian or Other Pacific Islander**

Persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

____ **PARENT OR GUARDIAN REFUSES TO LIST CHILD'S ETHNICITY AND RACIAL GROUP**

I (parent or guardian) refuse to designate the ethnicity of my child and understand that the school district is required by the United States Department of Education to determine the ethnicity of my child based on their observation of the student.

Parent or Guardian Signature _____

Date ____/____/____

FOR SCHOOL USE ONLY WHEN PARENT REFUSES TO LIST CHILD'S ETHNICITY AND RACIAL GROUP ABOVE

School District's determination of child's ethnicity based on observation:

____ Hispanic/Latino

____ White

____ Black or African American

____ Asian

____ American Indian or Alaskan Native

____ Native Hawaiian or Other Pacific Islander

Name of School District employee determining child's ethnicity (please print) _____

Employee Signature: _____

Date: ____/____/____

DEVELOPMENT, HEALTH, & SOCIAL HISTORY

STUDENT NAME: _____

EDUCATIONAL HISTORY:

Did your child attend preschool? _____ No _____ Yes

Where: _____ Dates Attended: _____

Has your child ever been evaluated for intervention services? _____ No _____ Yes

If Yes: Where: _____
 When: _____
 Type of Intervention received: _____

Past and/or Present Services Received:

_____ Previous Psychological Evaluation _____ IEP
_____ Speech Therapy _____ Physical Therapy
_____ Occupational Therapy
_____ Children's Service Agency - - Name _____
_____ Counseling Agency - - Name _____
_____ Private Physician - - Name _____

MEDICAL INFORMATION:

A. Prenatal

Health of mother during pregnancy: _____ Excellent _____ Fair _____ Poor

Were there any unusual events during pregnancy? (Drugs, bleeding, measles, spotting, toxemia, medication, etc.)

B. Birth

Was your child premature? _____ No _____ Yes How many weeks? _____

Were there any complications during pregnancy? _____ Caesarean _____ RH

_____ Breech Birth _____ Need for Oxygen _____ Toxemia

Baby's Birth Weight _____ Birth Defects _____

DEVELOPMENT, HEALTH, & SOCIAL HISTORY

C. Early Childhood

Has your child ever had:

Any Surgeries? _____ No _____ Yes

(Age & Reason) _____

High Fevers? _____ No _____ Yes

(Age & Temperature) _____

Ear Infections? _____ No _____ Yes

(Age or Ages) _____

Serious Injuries? _____ No _____ Yes

(Age or Ages) _____

D. Current Health Status

Date of your child's most recent examination:

_____ Physical Examination

Does your child have allergies? _____ No _____ Yes

If so, please list: _____

Has your child or does your child require any daily medications?

_____ No _____ Yes

If so, please list: _____

_____ Hearing Examination

Does your child require any hearing devices? _____ No _____ Yes

Explain: _____

_____ Vision Examination

Does your child wear glasses? _____ No _____ Yes

Explain: _____

DEVELOPMENT, HEALTH, & SOCIAL HISTORY

CURRENT BEHAVIORAL DATA:

Does your child like to play with: 1 or 2 other children large group alone

Temper Tantrums: No Yes How long do they last? _____

Does your child sleep well? No Yes Bedtime _____

Wet: Day Night Soils: Day Night

Most effective type(s) of discipline: _____

Check the characteristics that apply to your child most of the time:

Happy Shy Stubborn Friendly
 Aggressive Impulsive Inattentive Bored
 Moody Immature

Have a preferred hand? Left Right Neither

Comments: _____

Follow instructions or orders at home? No Yes

Comments: _____

Respect their own property or property of others? No Yes

Comments: _____

Respond to correction? No Yes

Comments: _____

EMERGENCY MEDICAL AUTHORIZATION
NILES CITY SCHOOL DISTRICT



STUDENT NAME _____
First Name Middle Initial Last Name
ADDRESS _____
Street City State Zip
HOME PHONE _____ CELL _____ DATE OF BIRTH ____/____/____
SCHOOL _____ TEACHER _____ GRADE _____ ROOM # _____

PURPOSE: TO ENABLE PARENTS AND GUARDIANS TO AUTHORIZE THE PROVISION OF EMERGENCY TREATMENT FOR CHILDREN WHO BECOME ILL OR INJURED WHILE UNDER SCHOOL AUTHORITY, WHEN PARENTS OR GUARDIANS CANNOT BE REACHED.

RESIDENTIAL PARENT OR GUARDIAN

MOTHER'S NAME _____ WORK PHONE _____ CELL # _____
FATHER'S NAME _____ WORK PHONE _____ CELL # _____
OTHER CONTACT _____ RELATIONSHIP _____ PHONE # _____
OTHER CONTACT _____ RELATIONSHIP _____ PHONE # _____
OTHER CONTACT _____ RELATIONSHIP _____ PHONE # _____

Are parents (Ck. One) Married Divorced Separated Never Married

If divorced, legal name of parent who has custody _____
Is non-custodial parent allowed to pick child up? YES NO

Name and address of non-custodial parent _____

If student is not living with either natural parent, please complete the following:

Student is living with _____
Name Relationship Phone

ADDRESS _____
Street City State Zip

STUDENT RELEASED ONLY TO CONTACTS LISTED ABOVE

COMPLETE EITHER PART I OR PART II, BUT NOT BOTH

PART I-TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

PHYSICIAN _____ PHONE # _____
DENTIST _____ PHONE # _____
MEDICAL SPECIALIST _____ PHONE # _____
LOCAL HOSPITAL _____ PHONE # _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonable accessible.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Please list the facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted _____

____/____/____
Date

Signature of parent/guardian

Address of parent/guardian

PART II-REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following actions _____

____/____/____
Date

Signature of parent/guardian

Address of parent/guardian