



CROOK COUNTY SCHOOL DISTRICT #1
MARK R. BRODERSON, SUPERINTENDENT

MOORCROFT K-8 SCHOOL
13 COUNTRY LANE
PO BOX 40
MOORCROFT, WY 82721

TERESA BROWN, PRINCIPAL
brownta@crook1.com

RELEASE OF RECORDS REQUEST

To – Previous School _____

Address _____

Fax # _____

Please send the following data for the student(s) named below who enrolled in our school on _____.

- | | |
|-------------------------------|--------------------------------|
| Birth Certificate | Immunizations & Health Records |
| Standards Report Card | 504/Accommodation Plan |
| Cumulative File | Psychological Testing Records |
| IEP/Special Education Records | Test Scores |
| Discipline Records | Other _____ |

Student's Name	Grade	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The undersigned hereby authorizes the release of his/her school records as defined in the Family Educational Rights and Privacy Act of 1974 to:

Moorcroft K-8 School
PO Box 40
Moorcroft, Wyoming 82721
Fax – 307-756-3681



Signature of Parent/Guardian

The State of Wyoming provides Hathaway Merit & Need Scholarships to Wyoming students attending the University of Wyoming and Wyoming community colleges. Every Wyoming student who meets the merit requirements can earn a Hathaway Merit Scholarship. Contact your school counselor for more information.



CROOK COUNTY SCHOOL DISTRICT #1

ENROLLMENT FORM

(PLEASE PRINT NEATLY)

Student Legal Name:

Last Name

First Name

Middle Name

Gender: M F Grade Level: Age: Date of Birth: / /

Place of Birth: Was this student born in the US? Yes No (Continue Below)

If NO, please list the country in which the student was born:

Is the Student Hispanic or Latino? Yes No What is the Student's Race: (select all that apply)

Asian

Caucasian

American Indian/Alaskan Native

Black or African American

Native Hawaiian or Other Pacific Islander

HOME LANGUAGE SURVEY

Language Spoken by the Student: English Other:

Primary Language Spoken at Home: English Other:

Language(s), other than English, spoken or understood by your child:

PREVIOUS SCHOOL INFORMATION

How many full years of education has the student completed in the U.S.?

Has your child previously attended school in Crook County?

Is your child on a current Individual Educational Plan (IEP)? Yes No

Has your child ever received Title I services? Yes No

Has your child ever received special education services? Yes No

Has your child ever received speech/language services? Yes No

How old was your child when he/she started kindergarten? 5 6

Has your child ever been retained? Yes No If yes, in what grade was your child retained?

Parent Signature

Date

Office Use Only:

School Entry Date: School Entry Grade Level: Verification:

Student lives with: (circle one)

Both Parents Father Mother Legal Guardian Other: _____

****If student is living with anyone other than birth parents, legal documentation of guardianship MUST be provided.****

Physical Address: _____

Mailing Address: _____

City, State ZIP: _____

Please fill out the information below (if it applies) for your student to receive school messages of emergencies, events, and activities.

Student Cell Phone: _____

Student Email: _____

PRIMARY CONTACT 1

PRIMARY CONTACT 2

Name: _____

Relationship: Father Mother
 Other _____

Home Phone: () - _____

Cell Phone: () - _____

Work Phone: () - _____

Employer: _____

Email: _____

Name: _____

Relationship: Father Mother
 Other _____

Home Phone: () - _____

Cell Phone: () - _____

Work Phone: () - _____

Employer: _____

Email: _____

****NON-CUSTODIAL PARENT/GUARDIAN**
COMPLETE IF APPLIES**

EMERGENCY CONTACTS

****If there are custody &/or visitation restrictions, please provide the school office copies of legal documentation.****

EMERGENCY CONTACT 1

Name: _____

Relationship: Father Mother
 Other _____

Mailing Address: _____

City, State ZIP: _____

Contact Allowed: YES NO

Home Phone: () - _____

Cell Phone: () - _____

Work Phone: () - _____

Employer: _____

Email: _____

Name: _____

Home: () - _____

Cell: () - _____

Work: () - _____

Relationship: _____

EMERGENCY CONTACT 2

Name: _____

Home: () - _____

Cell: () - _____

Work: () - _____

Relationship: _____

EMERGENCY CONTACT 3

Name: _____

Home: () - _____

Cell: () - _____

Work: () - _____

Relationship: _____



CROOK COUNTY SCHOOL DISTRICT #1

P.O. Box 830
 Sundance, WY 82729-0870
 T: 307-283-2299 F: 307-283-1810

Standard Student Residency Questionnaire

This questionnaire is intended to address the McKinney-Vento Act. Your responses will help the administrator determine residency status for enrollment of this student and whether or not additional support and services may be available to the student.

1.) Presently, where is the student living? *Check one box below*

Section A	Section B
<input type="checkbox"/> in a shelter, transitional housing, or awaiting foster care <input type="checkbox"/> with more than one family in a house or an apartment due to loss of housing or economic hardship <input type="checkbox"/> In a temporary trailer, campground, car, or park <input type="checkbox"/> In a hotel or motel <input type="checkbox"/> In a poorly habitable environment (lack of water, heat or kitchen facilities; insect or rodent infestation or similar situation) CONTINUE: <i>If you checked a box in Section A, complete #2 and the remainder of this form.</i>	<input type="checkbox"/> Choices in Section A do not apply <p><i>STOP: If you checked this section, you do <u>not</u> need to complete the remainder of this form. Submit to school personnel. Thank you.</i></p>

2.) The student lives with:

- | | |
|---|--|
| <input type="checkbox"/> 1 parent | <input type="checkbox"/> a relative, friend(s) or other adult(s) |
| <input type="checkbox"/> 2 parents | <input type="checkbox"/> alone with no adults |
| <input type="checkbox"/> 1 parent & another adult | <input type="checkbox"/> an adult that is not the parent or legal guardian |

School: _____

Name of Student _____ Male Female

Birth Date _____ (mm/dd/yyyy) Age _____ SS# (if applicable) _____

Name of Parent(s)/Legal Guardian(s) _____

Address _____ Zip _____ Phone _____

Signature of Parent/Legal Guardian _____ Date _____

If the parent/guardian has checked Section B above, completion of this form is not required. For any choices in Section A, this form must be immediately routed to the appropriate personnel. The original form must be kept separately from the Student Permanent Record for audit purposes during the year.

The name and phone number of a school contact person who may know of the family's situation:

Date Distributed: _____

CROOK COUNTY SCHOOL DISTRICT #1

STUDENT TRANSFER INFORMATION FORM

Student's Name _____ Date of Admission _____

Age _____ Grade _____ Birthdate _____

Previous School _____

City _____ State _____ Zip _____

Yes No

1. Was your child receiving special education services in his/her previous school? (e.g., Speech, Language, Hearing, Behavior, Physical or Academics) _____

2. Was your child enrolled in a Reading Recovery/Chapter/Title Program in his/her previous school? If "yes", which area of instruction? Language Reading Mathematics _____

3. Do you feel that your child may need extra instruction? If so, in which areas is he/she having difficulties? _____

Parent/Guardian Signature _____

Phone Number _____ Address _____

NOTE to District Personnel

- 1. No student may be placed in special education until a CST/IEP committee meets. Please call your assigned School Psychologist.
2. If previous special education is indicated, please specifically request special education record when writing for the child's records.
3. If appropriate, obtain parent/guardian permission for authorization for exchange of confidential information.



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Student Health Information

Student Name: _____ DOB: _____

HEALTH CONCERNS	YES	NO	MEDICATION (NAME & DOSE)	NECESSARY MONITORING IN SCHOOL	COMMENTS OR DESCRIBE
ASTHMA/ RESPIRATORY					
SEVERE ALLERGIES <ul style="list-style-type: none"> • Food, drugs, latex, Insect stings • Epi-Pen 					Type of reaction: Date of last reaction:
DIABETES					Must have doctors' orders accompanying enrollment.
HEAD INJURY					
SEIZURES/ NEUROLOGICAL/ MIGRAINES					
HEART/BLOOD					
MUSCLE/ BONES/ JOINTS/ SKIN					
BLADDER/KIDNEY					
HX CHICKEN POX DISEASE			DATE:		
STOMACH/ INTESTINES/BOWELS					
IMMUNE PROBLEMS					
OTHER HEALTH CONCERNS					
HEARING CONCERNS <ul style="list-style-type: none"> • Chronic ear infections • Ear tubes 				Hearing aids?	
VISION CONCERNS				Glasses or contacts? Reading only?	
EMOTIONAL/ BEHAVIORAL (ADHD)					

Signature of Parent or Legal Guardian: _____ Date: ____/____/____



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Please provide the following information:

1. Please list all prescription, over-the-counter, and herbal medications your child takes regularly:

2. List any hospitalizations or surgeries:

3. Pediatrician/primary care provider: _____ Phone: _____

4. Child's Health Insurance: None Medicaid Private/Commercial/Employer sponsored

Permission to exchange information with the doctor:

I, _____ (do) (do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to the form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____

Permission to share information:

I authorize the sharing of my child's health information identified on this student health information form to provide appropriate school services. This authorization is effective until revoked in writing by parent/guardian.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____

Permission to treat:

In case of an accident and I cannot be reached, I give the _____ School Permission to take my child to the closest medical clinic or hospital for treatment.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____



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CROOK COUNTY SCHOOL DISTRICT #1

Mark Broderson, Superintendent
Hulett- Moorcroft- Sundance
P.O. Box 830
Sundance, WY 82729-0870
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School Medication Policy

Student's Name: _____

The medical profession strongly advises that medications for school children should be administered at home. It should only be administered at school if such medication is absolutely necessary in order for the student to remain in school.

➤ **Elementary & MK-8 students are not allowed to keep medications (prescription or non-prescription) on their person.**

If your child must have a medication of any type in order to stay in school, the following procedure will be followed:

1. The school will not furnish medication under any circumstances.
2. Written instructions from a physician must be on file with the school before any medication is administered. This applies to prescription medication and non-prescription medications such as Tylenol or cough medication.
3. Students taking medications prescribed by a physician must present the medication in its container from a pharmacy with written permission from the parent authorizing dispensing of the medication to their child. Most pharmacies will provide more than one container, if requested, so that one container may be sent to school.
4. Any non-prescription medication sent to school with a student for administration, such as Tylenol or cough medications, must be in its original container from the manufacture.
5. School personnel will not dispense any type of medication without written permission from the **parent & physician** authorizing the administration of the medication.
6. Students shall be instructed to not "share" medications with other students.
7. It is the student's responsibility to go to the Nurse's Office for the medication. The school is under no obligation to see out the student should he/she forget.

➤ **Student in grades 7 through 12 or MHS 9-12 may keep medications with them under the following conditions:**

1. Only enough medication for one day should be kept by the student.
2. Medicines are not to be stored in a student's locker.
3. Medications must be in a properly labeled container from a pharmacy listing name of student, name and dose of medication, physician's name and date. Non-prescription medications must be in its original container from the manufacturer.
4. Students shall be instructed to no "share" medications with other students.
5. Students may keep more than a day's worth of over the counter medication in the nurse's locked cabinet

The School Nurses of Crook County School District request and appreciate your cooperation in adhering to this medication policy. This policy is in compliance with the Wyoming Nursing and Pharmacy Laws, and thereby assures the safety of our children. Loose pills in a pocket or in a "baggie" present a danger to other students at school and are not acceptable. It is no possible to prevent these unidentified medications from getting lost, stolen, or "shared" with other students.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____



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BUS TRANSPORTATION FORM

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

****List additional student on another sheet of paper and attach to this.****

Physical Address: _____

Parent/Guardian Name: _____

Phone: _____ Alt. Phone: _____

Date service to start: _____

Pick up address: _____

Phone: _____ Alt. Phone: _____

Drop off address: _____

Phone: _____ Alt. Phone: _____

Allergies/Other Information for Bus Driver: _____

Parent/Guardian Signature _____

Date _____