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
_____ American Indian/Alaskan Native Asian
_____ Native Hawaiian or Other Pacific Islander
_____ Caucasian
_____ Black or African American

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: _____

Is the student in foster care? Yes No

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

Is one, or both, of the student's parents and/or guardian on Active Duty, in the National Guard, or in the Reserve components of the United States military services?
Not Military Connected Active Duty National Guard or Reserve

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

Name: _____

Relationship: □ Father □ Mother □ Other _____

Home Phone: ( ) -

Cell Phone: ( ) -

Work Phone: ( ) -

Employer: _____

Email: _____

PRIMARY CONTACT 2

Name: _____

Relationship: □ Father □ Mother □ Other _____

Home Phone: ( ) -

Cell Phone: ( ) -

Work Phone: ( ) -

Employer: _____

Email: _____

NON-CUSTODIAL PARENT/GUARDIAN COMPLETE IF APPLIES

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

Name: _____

Relationship: □ Father □ Mother

Mailing Address: _____

City, State ZIP _____

Contact Allowed: □ YES □ NO

Home Phone: ( ) -

Cell Phone: ( ) -

Work Phone: ( ) -

Employer: _____

Email: _____

EMERGENCY CONTACTS

EMERGENCY CONTACT 1

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
Preparing Today for Success Tomorrow

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

2.) The student lives with:

- ☐ 1 parent
- ☐ 2 parents
- ☐ 1 parent & another adult
- ☐ a relative, friend(s) or other adult(s)
- ☐ alone with no adults
- ☐ 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/ RESPIRATROY					
SEVERE ALLERGIES • 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 • Chronic ear infections • Ear tubes				Hearing aids?	
VISION CONCERNS				Glasses or contacts? Reading only?	
EMOTIONAL/ BEHAVIORAL (ADHD)					

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

WYOMING HATHAWAY SCHOLARSHIP PROGRAM

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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 heal 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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Mark Broderson, Superintendent
Hulett- Moorcroft- Sundance
P.O. Box 830
Sundance, WY 82729-0870
T: 307-283-2299 F: 307-283-1810

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 on 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 it 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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Wyoming Department of Health

IMMUNIZATION AGREEMENT BETWEEN PARENT/GUARDIAN AND SCHOOL

To ensure the Wyoming Department of Health is aligning with the Health Insurance Portability and Accountability Act (HIPAA), Wyoming schools must obtain parent/guardian agreement before accessing a student's immunization record within the Wyoming Immunization Registry (WyIR) for proof of immunization.

Parent/guardian agreement must be maintained in the student's school file and made available to the Wyoming Department of Health upon request.

I, _____, am the parent/guardian of _____. I
(Parent/Guardian Name) (Child's Name)

agree that the designated administrative official, such as the school nurse, representing

_____ has my permission to access this student's immunization
(Name of School)

record in the WyIR to obtain proof of immunization in order to meet the school entry requirements in accordance with Wyo. Stat. Ann. § 21-4-309.

_____ _____
Parent/Guardian Signature Date

Wyoming Department of Health

Immunization Unit
Public Health Division
6101 Yellowstone Road, Suite 420
Cheyenne, WY 82002
307-777-7952 • 800-599-9754
Fax 307-777-3615 www.immunizewyoming.com
www.health.wyo.gov

Thomas O. Forslund
Director

Matthew H. Mead
Governor

VERIFICATION OF DISEASE STATEMENT: VARICELLA-ZOSTER VIRUS (CHICKENPOX)
For Children Attending Schools and Child Caring Facilities

Wyo. Stat. Ann. §§ 21-4-309 and 14-4-116, requires any person attending, full or part time, any public or private school or child caring facility, to be immunized against the vaccine-preventable diseases designated by the State Health Officer.

This form must be completed by a physician, nurse practitioner, physician's assistant or physician's designee to serve as verification that a child has had the varicella-zoster virus.

Directions:

1. Only complete this form for a child that has had the **CHICKENPOX.**
2. Use one form per child.
3. A copy of this form must be returned to the Preschool/School/Child Caring Facility in which the child is enrolled.

Evidence of immunity in lieu of age-appropriate varicella vaccination includes any of the following:

- Laboratory evidence of immunity or laboratory confirmation of disease, or
- Diagnosis or verification of a history of varicella or herpes zoster by a health care provider.

To verify a history of varicella, health care providers should inquire about:

- An epidemiologic link to another typical varicella case or to a laboratory confirmed case, or
- Evidence of laboratory confirmation, if testing was performed at the time of acute disease.

Persons who have neither an epidemiologic link nor laboratory confirmation of varicella should not be considered as having a valid history of disease. For these persons, a second dose of vaccine is recommended if they previously received only one dose. If a health care provider verifies the diagnosis based on the above criteria, then vaccination is not needed.

Physician's Statement

Child's Full Name: _____ **Date of Birth:** _____

By signing this statement, I am verifying that the child named above had the varicella-zoster virus approximately on or about _____ and therefore does not need the varicella vaccine. I understand that this document will be included in the child's permanent record.
(date or year)

_____ _____

Printed Name of Health Care Provider **Signature**

_____

Date