



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 Asian

Black or African American

Native Hawaiian or Other Pacific Islander

HOME LANGUAGE SURVEY

This information is used solely to ensure appropriate services, not for determining legal status for immigration purposes

What language did the child first learn? English _____ Other _____

What language does the child currently use most at home? English _____ Other _____

What is the primary language used by the family? English _____ Other _____

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? _____

Has your child ever been expelled from any school? _____

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

Is your child on a current 504 plan? 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? _____

Parent Signature

Date

Office Use Only:

School Entry Date: _____ School Entry Grade Level: _____ Verification: _____

Is one, or both, of the student's parents and/or guardian on Active Duty, in the National Guard, in the Reserve components, or Part-time military service of the United States military services?

Not Military Connected Active Duty National Guard or Reserve Part-time Military

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.****

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 (with whom student resides)

PRIMARY CONTACT 2 (with whom student resides)

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

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: _____



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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"/> Shelter or transitional housing <input type="checkbox"/> Doubled-up <input type="checkbox"/> Unsheltered <input type="checkbox"/> Hotel/Motel 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 <u>STOP:</u> <i>If you checked this section, sign the bottom of the form and date. You do <u>not</u> need to complete question #2.</i>

- 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: _____



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TRANSPORTATION FORM

Student Name: _____ Grade: _____

Physical Address: _____

Parent/Guardian Name: _____

Phone: _____ Alt. Phone: _____

E-mail Address: _____

Please indicate how your child will be transported to and from school:

_____ Vehicle _____ Walk

_____ CCSD#1 Bus (Continue Below) _____ Other

If using CCSD #1 bus- please continue below:

Date service to start: _____

Pick up address:

Address: _____

Phone: _____ Alt. Phone: _____

Drop off address (if different than above):

Address: _____

Phone: _____ Alt. Phone: _____

Allergies/Other Information for Bus Driver: _____

Parent/Guardian Signature

Date

OFFICE USE ONLY: : _____



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FAMILY 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: _____

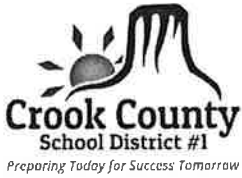
Drop off address: _____

Phone: _____ Alt. Phone: _____

Allergies/Other Information for Bus Driver: _____

Parent/Guardian Signature

Date



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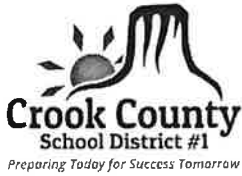
Student Health Information

Student Name: _____ DOB: _____

HEALTH CONCERNS	YES	NO	MEDICATION (NAME & DOSE)	NECESSARY MONITORING IN SCHOOL	COMMENTS OR DESCRIBE
ASTHMA/ RESPIRATORY					
SEVERE ALLERGIES Food, drugs, latex, Insect stings Epi-Pen					Type of reaction: Date of last reaction:
DIABETES					Must have doctors' orders accompany- ing enrollment.
HEAD INJURY					
SEIZURES/ NEUROLOGI- CAL/ MIGRAINES					
HEART/BLOOD					
MUSCLE/ BONES/ JOINTS/ SKIN					
BLADDER/KIDNEY					
HX CHICKEN POX DIS- EASE			DATE:		
STOMACH/ INTESTINES/BOWELS					
IMMUNE PROBLEMS					
OTHER HEALTH CON- CERNS					
HEARING CONCERNS Chronic ear infec- tions Ear tubes				Hearing aids?	
VISION CONCERNS				Glasses or con- tacts? Reading only?	
EMOTIONAL/ BEHAVIORAL (ADHD)					

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

Continued →



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Student Health Information

Please provide the following information:

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

List any hospitalizations or surgeries:

Pediatrician/primary care provider: _____ Phone: _____

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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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:

The school will not furnish medication under any circumstances.

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.

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.

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.

School personnel will not dispense any type of medication without written permission from the **parent & physician** authorizing the administration of the medication.

Students shall be instructed to not "share" medications with other students.

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:

Only enough medication for one day should be kept by the student.

Medicines are not to be stored in a student's locker.

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.

Students shall be instructed to not "share" medications with other students.

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 not 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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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

Parent/Guardian Name

_____. I agree that the designated administrative official,

Student Name

such as the school nurse, representing _____

Name of School

has my permission to access this student's immunization 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