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

MOORCROFT K-8 SCHOOL
13 COUNTRY LANE/ P.O. BOX 40
MOORCROFT, WY 82721
Lori Enright, Principal
enrightl@crook1.com
Sherry Ewing, Assistant Principal
ewings@crook1.com

RECORDS RELEASE

Please send the school records of:

Student Name	Date of Birth	Grade

who enrolled in Crook County School District #1 on _____.
Date

Name of Previous School	Phone Number
Address	Fax Number
City, State Zip	Signature of Parent/Guardian

Please include all of the following:

Birth Certificate	Immunizations & Health Records
Current Classes & Grades	Standards Report Card
Cumulative File	Test Scores
IEP/Special Education Records	504/Accomodation Plan
Psychological Testing Records	Discipline Records
Attendance Records	Other_____

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

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:	**Name:**
Relationship: □ Father □ Mother □ Other _____	**Relationship:** □ Father □ Mother □ Other _____
Home Phone: ( ) -	**Home Phone:** ( ) -
Cell Phone: ( ) -	**Cell Phone:** ( ) -
Work Phone: ( ) -	**Work Phone:** ( ) -
Employer:	**Employer:**
Email:	**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:

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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
□ Shelter or transitional housing □ Doubled-up □ Unsheltered □ Hotel/Motel **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, sign the bottom of the form and date. You do not need to complete question #2.**

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: _____

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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/ 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: ____/____/_____

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 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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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 on 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 it 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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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
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