

# GRANDVIEW SCHOOL Enrollment Form

FOR SCHOOL USE ONLY:	
Student ID# _____	_____
School Year _____ - _____	_____
Start Date _____	_____

Student Full Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
First Middle Last (MM-DD-YY)

Gender: **Male/Female** Race: **Black/White/Indian/Other** Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Place of Birth (City/State): \_\_\_\_\_

Check if you have provided a copy of the following: \_\_\_\_\_ Birth Certificate \_\_\_\_\_ SS Card \_\_\_\_\_ Shot Record

Student lives with: \_\_\_\_\_ Both \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other: \_\_\_\_\_

Parent/Guardian(s) \_\_\_\_\_  
First and Last Name(s)

Home Address \_\_\_\_\_  
Street Address City State Zip

Best Number(s) by which to reach you...**please indicate if it is HOME, CELL, or WORK.**

( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
HOME / WORK / CELL HOME / WORK / CELL HOME / WORK / CELL

Mother's Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Employer \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

School Age Siblings: Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

**Emergency Contacts** - Please list at least **TWO** people whom we may call in case of an emergency and/or may pick up your child if needed.

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

**School Information:**

Last school attended (other than Grandview) \_\_\_\_\_

How will your child get to/from school? \_\_\_\_\_ Ride the bus \_\_\_\_\_ Car Rider

Does this student have an IEP? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does this student require the use of an inhaler? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does this student have any food allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what kind? \_\_\_\_\_

\* We use the REMIND Mass Messaging system to send out important information such as upcoming dates and school closings. We strongly encourage everyone to sign-up for this in order to be kept in the loop. You do not have to have a smart phone, either. Simply text this message @grand55 to this number 81010. You will receive a text message asking you to confirm. If you ever change your phone number, you will have to re-register in the system.

\*We provide a free After School Program that ENDS PROMPTLY at 5:30PM. This program may be utilized by parents who work or go to school full time, and are unable to pick up from school or at home to meet the bus. Please visit with our office staff for further information.

\_\_\_\_\_ Yes, I am aware of these guidelines.

\*FIELD TRIPS - We plan several field trips every year. By signing this section, you're giving permission for all field trips during the current school year. Your child's teacher will provide more detailed information prior to any field trips planned.

\_\_\_\_\_ Yes, I give permission.

\*MEDIA RELEASE - Grandview School has a website! By signing this section, you're giving permission for your child's picture to be posted to our website, any newspaper publications, any classroom Facebook pages, and our annual yearbook.

\_\_\_\_\_ Yes, I give permission.

### Medical Information & Authorization

Pediatrician/Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Clinic/Hospital Preference \_\_\_\_\_

Please List/Describe any medical conditions your child may have (Examples: Allergies, Asthma, Vision/Hearing impairments, anything that may affect his/her daily life at school):

I authorize a representative of Grandview School to administer and/or sign for any emergency medical treatment for my child.

X \_\_\_\_\_

I authorize a representative of Grandview School to administer **Advil / Tylenol** to my child for minor aches/pains (chewables may be substituted for smaller children). **Circle one or both.**

X \_\_\_\_\_

I authorize a representative of Grandview School to administer \_\_\_\_\_, a filled prescription medication which I am supplying, or will supply when required, in accordance with direction of administering as listed on the vial label; or according to any written instructions by the prescribing physician. ALL prescription medication MUST be sent to school in a labeled pharmaceutical vial.

X \_\_\_\_\_

I understand that under state law, the school board, the school district, or employees of the district shall not be liable to the student or the student's parents/guardians for civil damages in the event of personal injury to the student which may result from the act of administering, or the omission of administering, the medication I have hereby authorized.

Any comments about your child's discipline:

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\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date