

## School Enrollment/Emergency Information 2016-2017

**STUDENT INFORMATION:**

Name: \_\_\_\_\_ Date of Birth (required) \_\_\_\_\_

Ethnic Code:   Caucasian   American Indian   African American   Asian   Hispanic   *(please check all that apply)*

If American Indian, name of tribe \_\_\_\_\_ Enrolled member:   Child   Child's parent   Child's Grandparent

My child received services by one of the following at his/her former school:   Special Education/Resource   Title I Reading/Math

Other (please specify) \_\_\_\_\_

**PARENT INFORMATION: Parent/Legal Guardian**

★Physical Address (required): \_\_\_\_\_

★Mailing Address (if different than above) \_\_\_\_\_

Father's name: _____	
Home # _____	Work #: _____
Cell # _____	Receive Report Card:   Yes   No
E-Mail: _____	

Mother's name: _____	
Home # _____	Work #: _____
Cell # _____	Receive Report Card:   Yes   No
E-Mail: _____	

I hereby voluntarily consent to emergency treatment and first-aid screening examinations and minor treatment as may be deemed necessary by a physician or school nurse. When unable to contact parent or personal physician, I hereby give permission to the school to authorize necessary treatment, until parent and/or physician can be notified.   Yes   No

**Emergency Contact** \_\_\_\_\_ **Emergency day phone number** \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Emergency day phone number** \_\_\_\_\_

**Doctor Name** \_\_\_\_\_ **Doctor Phone number** \_\_\_\_\_

**Special Medical Conditions/Allergies**

Medications:   Yes   No   If Yes, explain \_\_\_\_\_

I, the undersigned (as a parent or guardian of the participant, a minor), hereby authorize the staff of Valley View School as my agents, to consent to medical, surgical or dental examination and/or treatment. In case of emergency, I hereby authorize treatment and/or care at any hospital or by licensed medical personnel. Staff will NOT medicate children. Parents/guardians are ENTIRELY responsible for medications and for personally arranging for or insuring the proper and timely medicating of their child.

<b>★Persons authorized to pick up student: Please call and tell who you are sending, or bring a Photo I.D. We may not know them!</b>		
Name: _____	Relationship to student: _____	Phone: _____
Name: _____	Relationship to student: _____	Phone: _____
Name: _____	Relationship to student: _____	Phone: _____

**Acknowledgment and Consent: For Internal and external use, I acknowledge that the Valley View School District 35 and/or its sponsors may utilize film, print, and digital images of a student or a family, which may be taken during involvement in any/all of Valley View School activities. I consent to such uses & hereby waive all rights to compensation.**

**Initial** \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent or Guardian**

<i>For Office Use Only:</i>	
<input type="checkbox"/> Internet Use Agreement	<input type="checkbox"/> Coalition Registration
<input type="checkbox"/> Handbook Agreement	<input type="checkbox"/> Medication/First Aid Permission
<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Release of Immunization Records
	<input type="checkbox"/> Shot Record

VALLEY VIEW ELEMENTARY "AFTER SCHOOL" REGISTRATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_\_

I, the undersigned (as a parent or guardian of the participant, a minor), hereby give permission for mutual exchange of information between the 21<sup>st</sup> Century After School Program and the school regarding health and safety issues, food program status, immunization records and academic achievement.

Signature: \_\_\_\_\_

**Acknowledgment and Consent:** For Internal and external use, I acknowledge that the 21<sup>st</sup> Century After School Program and/or its sponsors may utilize film, print, and digital images of a student or a family, which may be taken during involvement in the 21<sup>st</sup> Century After School Program activities. I consent to such uses & hereby waive all rights to compensation. Initial \_\_\_\_\_

**Persons authorized to pick up Student:**

Name \_\_\_\_\_ Relationship to student \_\_\_\_\_ Phone: \_\_\_\_\_

Name \_\_\_\_\_ Relationship to student \_\_\_\_\_ Phone: \_\_\_\_\_

Name \_\_\_\_\_ Relationship to student \_\_\_\_\_ Phone: \_\_\_\_\_

**Medical Information:**

Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Serious Health Problems:    No    Yes        If Yes, explain \_\_\_\_\_

Medications:    No    Yes        If Yes, explain \_\_\_\_\_

I, the undersigned (as a parent or guardian of the participant, a minor), hereby authorize the staff of the 21<sup>st</sup> Century After School Program volunteers, coaches, trainers, supervisors, instructors and drivers as my agents, to consent to medical, surgical or dental examination and/or treatment. In case of emergency, I hereby authorize treatment and/or care at any hospital or by licensed medical personnel. Staff will NOT medicate children. Parents/guardians are ENTIRELY responsible for medications and for personally arranging for or insuring the proper and timely medicating of their child.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Valley View Elementary School 2016-2017**

PLEASE SIGN AND DETACH THIS PAGE AND RETURN IT TO YOUR CHILD'S TEACHER.

**My child and I have read and understand the school policies found in the Parent /Student Handbook.**

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Parent/Guardian Signature

Date

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Child's Name

Teacher

**RELEASE OF IMMUNIZATION RECORD PERMISSION**

I give permission for Lake County Health Department to enter my child's vaccine information into the statewide immunization database, the Montana Public Health Data System (PHDS). This information will be shared with health care providers to help prevent both over and under immunization and to develop one consolidated vaccine record for the child.

**CHILD'S NAME** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

**I do not want my child's vaccine information entered into the Montana Public Health Data System.**

**CHILD'S NAME** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_