School Enrollment/Emergency Information
2017-2018

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 Title I 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.

✶**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!**

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

For Office Use Only:

___ Internet Use Agreement
___ Handbook Agreement
___ Birth Certificate
___ Coalition Registration
___ Medication/First Aid Permission
___ Release of Immunization Records
___ 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 21st 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 21st 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 21st 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 21st 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 2017-2018

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.

____

Parent/Guardian Signature   Date

____

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__________________