SCHOOL DISTRICT OF GREENWOOD

FAMILY ENROLLMENT FORM

(PLEASE COMPLETE BOTH SIDES OF THIS FORM - FILL OUT ONE FORM PER FAMILY)

START DATE: _____

FULL LEGAL NAME (FIRST, MIDDLE, & LAST) OF ALL CHILDREN IN HOUSEHOLD UNDER THE AGE OF 21	DATE OF BIRTH	GENDER M/F	GRADE	SOCIAL SECURITY #

HOME ADDRESS

Street/Mailing Address: _____

City: _____ Zip Code: _____ Township: _____

Home #: _____ Home Phone # Confidential: ☐ **YES** ☐ **NO**

RESIDING PARENT/GUARDIAN INFORMATION

1 **NAME :** _____

FIRST MIDDLE LAST

Relationship: ☐ **FATHER** ☐ **STEP-FATHER** ☐ **GUARDIAN** ☐ **FOSTER PARENT**
☐ **MOTHER** ☐ **STEP-MOTHER** ☐ **OTHER** (Relationship): _____

Place of Employment: _____ Position: _____

Work #: _____ Cell #: _____

E-Mail Address: ☐ Home ☐ Work _____

2 **NAME :** _____

FIRST MIDDLE LAST

Relationship: ☐ **FATHER** ☐ **STEP-FATHER** ☐ **GUARDIAN** ☐ **FOSTER PARENT**
☐ **MOTHER** ☐ **STEP-MOTHER** ☐ **OTHER** (Relationship): _____

Place of Employment: _____ Position: _____

Work #: _____ Cell #: _____

E-Mail Address: ☐ Home ☐ Work _____

2ND PARENT INFORMATION:

NAME : _____
FIRST MIDDLE LAST

Relationship: ☐ **FATHER** ☐ **MOTHER** _____ ☐ **OTHER**

Address: _____

City: _____ Zip: _____ Township: _____

Home #: _____ Home Phone # Confidential: ☐ **YES** ☐ **NO**

Cellular #: _____ Work #: _____

Place of Employment: _____ Position: _____

E-Mail Address: (Address you would like to have staff contact you at): _____

Are reports to be sent? ☐ **YES** ☐ **NO** *(Legal documentation may be requested.)*

EMERGENCY CONTACT INFORMATION

Alternate person to call for emergency treatment if parents cannot be reached. If parent cannot be reached, the emergency contact people will also be used for attendance notification purposes.

1. NAME: _____ RELATIONSHIP: _____
   HOME #: _____ WORK #: _____

2. NAME: _____ RELATIONSHIP: _____
   HOME #: _____ WORK #: _____

IF SCHOOL IS DISMISSED EARLY FOR ANY REASON, PLEASE LIST WHERE YOUR CHILD SHOULD BE SENT.

☐ Send home regularly (bus/walk) ☐ Call me at (Location/Ph. #): _____

Send to: _____

EMERGENCY TREATMENT

☐ **YES** ☐ **NO** ***If emergency treatment is required and parents/guardians cannot be reached immediately may school authorities use their judgment in calling the physician listed below, or if not available, an alternate physician?***

Family Physician: _____ Phone #: _____

Clinic/Hospital Name: _____ Phone #: _____

Parent/Guardian Signature: _____ **Date:** _____

ETHNIC GROUP

❑ White, Non-Hispanic; ❑ Black, Non-Hispanic ❑ American Indian or Alaskan Native
❑ Asian or Pacific Islander ❑ Hispanic

SPECIAL EDUCATION

DO STUDENT(S) HAVE A IEP, 504, OR SPECIAL EDUCATION STATUS ON FILE? ❑ **YES** ❑ **NO**

(List names of student(s) and approx. date of last IEP):

NAME _____ DATE: _____
NAME:_____ DATE: _____
NAME:_____ DATE: _____

BIRTHPLACE INFORMATION

ALL NEW STUDENTS ARE REQUIRED TO SUBMIT A COPY OF THEIR BIRTH CERTIFICATE AT TIME OF REGISTRATION.

PLEASE ENTER REQUESTED INFORMATION ON EACH OF YOUR CHILDREN'S PLACE OF BIRTH.

Name: _____ City: _____ County: _____ State: _____
Name: _____ City: _____ County: _____ State: _____
Name: _____ City: _____ County: _____ State: _____
Name: _____ City: _____ County: _____ State: _____
Name: _____ City: _____ County: _____ State: _____
Name: _____ City: _____ County: _____ State: _____

EDUCATION HISTORY

Name of school last attended:_____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

BUSING INFORMATION

_____ Miles from school. If busing is required will student(s) be bused from the home address?
❑ **YES** ❑ **NO** (If checked please fill out information below.)

WHERE WILL YOUR STUDENT(S) BE PICKED UP?

Name: _____ Phone #: _____
Address: _____
City: _____ Bus Driver (If known):_____

MEDICAL/HEALTH INFORMATION

(Please list name(s) of student before each health problem)

_____	Allergies (please list below)	_____	Heart Condition	_____	Vision Problems (not glasses)
_____	Asthma	_____	Hearing Problems		
_____	Attention Deficit	_____	Hyperactive	_____	Migraines/Headaches
_____	Central Auditory	_____	Lactose Intolerance	_____	Other Heath Conditions
_____	Processing	_____	Osgood Schlatter's	_____	_____
_____	Dysfunction	_____	Physically Challenged	_____	_____
_____	Diabetes	_____	Seizures	_____	_____
_____	Epileptic Seizures	_____	Stomach Problems	_____	_____

Please list specific allergies and/or any emergency health conditions your child may have. Please indicate the procedures you wish staff to follow below:

_____

_____

_____

_____

_____

_____

MEDICATIONS

Any student that is to receive any medications on school property must have a Medication Authorization form on file.

STUDENT'S NAME:	**MEDICATION TAKEN OR HEALTH CONCERNS:**
_____	_____
_____	_____
_____	_____
_____	_____

***WISCONSIN'S INDIVIDUAL STUDENT ENROLLMENT SYSTEM—**The Wisconsin Individual Student Enrollment System (ISES) is an electronic data collection system that has been created in response to the federal No Child Left Behind Act (NCLB). The NCLB Act requires extensive new data collection and reporting for schools, districts, and the state. Every public school student in Wisconsin will be assigned a unique number, called the Wisconsin Student Number (WSN), which will allow educators to better account for students who move frequently, more readily exchange student records among school districts, and respond more quickly to student needs. **REQUIRED DATA FIELDS INCLUDE:** STUDENT NAME - first, middle, last (legal name); PARENT (S)/GUARDIAN(S) NAME(S) – first, middle and last (legal name); BIRTH DATE; PLACE OF BIRTH – County, City, State; GENDER; RACE/ETHNICITY.