



KINDERGARTEN AND NEW ENROLLEES TO DISTRICT
STUDENT REGISTRATION INFORMATION

It is the responsibility of the parent/guardian to keep this information updated on a regular basis

Student's Last Name: First Name: MI:

Grade: Male: Female:

Birth Date: Birth Place:

Home Address: City: State: Zip:
(Must be actual physical address not a PO Box)

Mailing Address: City: State: Zip:
(If different than home address)

Primary Phone#: Parent/Guardian:

Federal Ethnicity and Race

Student's Ethnicity: Is the student Hispanic or Latino? () Yes () No

Student's race (circle one): (C) Caucasian (B) Black or African American (A) Asian (I) American Indian/ Alaskan Native (P) Native Hawaiian/Other Pac Islander

Father's Last Name: First Name:

Father's Primary Phone #: Father's Work Phone#:

Father's Employer:

Father's E-mail Address:

Guardian's Name (if other than parent):

Guardian's Home Address:

Guardian's Primary Phone#: Guardian's Work Phone#:

Guardian's E-mail Address:

Mother's Last Name: First Name:

Mother's Primary Phone#: Mother's Work Phone#:

Mother's Employer:

Mother's E-mail Address:

With whom does the student live now?

Mother: Father: Stepmother: Stepfather:

Grandmother: Grandfather: Adoptive Parent: Legal guardian:

Foster parents: Group home: Other (describe relationship):

Is this a single parent household? () Yes () No

EMERGENCY CONTACTS

Emergency Contact Person: Phone#: Relationship:

Emergency Contact Person: Phone#: Relationship:

Emergency Contact Person: Phone#: Relationship:

Other Adult(s) living in the home with the student:

Name: _____ Relationship to student: _____
 Name: _____ Relationship to student: _____
 Name: _____ Relationship to student: _____

How many total siblings does the student have? _____ How many live at home? _____

Please list siblings below:

<u>NAME</u>	<u>AGE</u>	<u>SCHOOL/OCCUPATION</u>	<u>GRADE</u>	<u>AT HOME?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EDUCATION HISTORY

In the past, has your child encountered any problems in school with (please check appropriate areas):

Attendance _____ Behavior _____ Grades _____ Retention _____
 Suspension _____ Expulsion _____ Academic _____ Achievement _____

Has your child been in special programs such as Title I, Special Education, Remedial Reading, Gifted, etc.?
 Please explain.

List all schools (including BCS) this student has attended, including daycare, pre-school, and kindergarten:

SCHOOL NAME	ADDRESS	CITY/STATE	GRADE	DATES ATTENDED
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

By signing this form, I verify that the above information is true and correct to the best of my knowledge and belief.

Signature: _____ Date: _____

MILITARY SURVEY

Is Parent or Guardian currently a member of the armed forces? () Yes () No

If yes: () Active Duty () Guard () Reserves

Belen Consolidated Schools HEALTH AUTHORIZATION FORM

PURPOSE: To enable parents/guardians to AUTHORIZE emergency treatment for a child who becomes ill or injured while under school authority, when parent's cannot be reached. Upon completion, this form must be returned to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian. **PLEASE COMPLETE ALL THREE SECTIONS!**

Last Name:	First Name:	Middle Initial:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
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NAME OF SCHOOL ATTENDED LAST SCHOOL YEAR:

SECTION ONE - STUDENT EMERGENCY CONTACT INFORMATION

In the event your child becomes sick or injured and needs to be sent home or to the ER, the school health office will always attempt to reach the Parent/Guardian listed below FIRST. Secondary contacts will be called if the parent/guardian cannot be reached. **PLEASE KEEP THESE NUMBERS CURRENT!**

Parent/Guardian Name:	Address:	Phone #1
		Phone #2
Check all that apply: <input type="checkbox"/> Lives With <input type="checkbox"/> Legal Guardian		Phone #3
Parent/Guardian Name:	Address:	Phone #1
		Phone #2
Check all that apply: <input type="checkbox"/> Lives With <input type="checkbox"/> Legal Guardian		Phone #3

Immunization requirements for attendance at school are governed by public health law, state regulations, and school policy. Your child is **CONDITIONALLY REGISTERED** depending on the review of his/her immunization records. The immunization records presented for registration must be current. The nurse will review all immunization records prior to the first day of school and will inform you if all are current. If all immunizations are current, your child's registration will be complete and he/she will be able to attend school. By initialing in the box, I confirm I have read and understand my child is CONDITIONALLY REGISTERED depending on the review of his/her immunization records. Initial here

Siblings in Other Schools

	Name	School/Daycare	Grade	DOB
1.				
2.				
3.				

SECTION TWO - STUDENT HEALTH HISTORY – Please check appropriate box

My child has no health conditions including those listed below

<input type="checkbox"/> Allergies:	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Food (List):	<input type="checkbox"/> Other Allergy (List):	<input type="checkbox"/> Has EpiPen prescription
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Congenital/Genetic	<input type="checkbox"/> Ear/Nose/Throat	<input type="checkbox"/> Pulmonary (Other than Asthma)	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eye/Vision	<input type="checkbox"/> Diabetes (circle one)	<input type="checkbox"/> Cardiovascular (List) _____	
Needs Inhaler at School: Y N	Wears glasses/contacts: Y N	Type 1 Type 2	High Blood Pressure: Y N	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Dermatologic/Skin	<input type="checkbox"/> Stomach/GI	<input type="checkbox"/> Musculoskeletal	
Long Term Medications (List):	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Bladder/GU	<input type="checkbox"/> Dental/Oral	
	<input type="checkbox"/> Endocrine Other than Diabetes	<input type="checkbox"/> Hematology/Bleeding Disorders	<input type="checkbox"/> Psychiatric (List Meds):	
<input type="checkbox"/> Any Other Health Conditions:		<input type="checkbox"/> Migraines		

SECTION THREE - INSURANCE INFORMATION

Student's Insurance:	Subscribers Name:	ID#
TO GRANT CONSENT		
In case of an emergency involving my child AND I CANNOT BE REACHED, I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:		
Healthcare Provider:	Phone:	
Dentist:	Phone:	
Hospital:	Phone:	

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this card will be shared with appropriate personnel on an as-needed basis only. I, also, understand health screenings (including vision, hearing, height, weight, blood pressure, and BMI) may be done by school health personnel unless I provide the school health office with written notification requesting exclusion from these screenings.

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

Last Name:

First Name:

NEW MEXICO STUDENT RESIDENCY QUESTIONNAIRE FORM

School _____

Your child may be eligible for additional educational service through Title I Part A, Title I Part C, Migrant, and/or Title X, Part C, Federal McKinney-Vento Assistance Act. Eligibility can be determined by completing this questionnaire.

1. Presently, where are you and your family currently staying? Check one box.

Section A

Rent/own my own home.

STOP: if you rent/own your own home, sign under item 5 and submit form to school personnel.

Section B

Temporarily with another family because we cannot afford or find affordable housing.

With an adult that is not a parent or legal guardian, or alone without an adult.

In motel, hotel, trailer park or campground without running water/electricity.

In a vehicle of any kind, abandoned building or substandard housing.

In an emergency/transitional shelter.

Other

CONTINUE: If you checked a box in Section B, complete the remainder of this form.

2. Have you moved in the past 3 years to seek work as a paid laborer in any type of farming (sod, dairy, chicken, vegetable, citrus, or other) or fishing? (Check One) Yes _____ No _____

3. If you checked a box in Section B, your child maybe eligible for additional educational services through Title I, Part A, Title I Part C - Migrant, or Title X, Part C - Federal McKinney-Vento Assistance Act.

First	Students(s) Name		SS #	M/F	D.O.B.	Grade	School Name
	Middle	Last					

4. Would you like to be contacted by a member of the school system;s Education for Homeless Children and Youth program staff: Yes No

5. The undersigned certifies that the information provided above is accurate.

Print Parent/Guardian Name/Adult Caring for Student

Signature

Date

(Area Code) Phone Number

Street Address

City

St

Zip

School Use Only

Free or Reduced Price Meals Form submitted/signed

Referral Form completed/submitted

Print School Contact

Title

Signature (required)

Date

FOR DISTRICT USE ONLY

District:

School:



NEW MEXICO PUBLIC EDUCATION DEPARTMENT
LANGUAGE USAGE SURVEY
~for parent or guardian to complete~

The purpose of this survey is to ensure that your child receives the highest quality education and services to which he or she is entitled. The information you provide will be used only to assist the school in making program decisions. You will complete this form only once in your child's educational career.

Student's Name:

Date of Birth:

Grade Level:

Answer each question by marking either the **YES** or **NO** box.

YES

NO

1. Does the student use a language(s) other than English with his/her family and friends?

2. Do you use a language(s) other than English with the student?

3. Does the student understand when someone communicates with him/her in a language other than English?

4. Does the student read in a language(s) other than English?

5. Does the student write in a language(s) other than English?

6. Does the student interpret for you or anyone else in a language(s) other than English?

7. If you answered YES on one or more of questions 1-6, what language(s) other than English does the student use most frequently at home? Choose up to three.

 American Sign Language (ASL) Arabic Cantonese Diné French Greek Hmong Jicarilla Apache Italian Keres Khmer Korean Mescalero Apache Mandarin Portuguese Russian Somali Spanish Tiwa Tewa Towa Vietnamese Zuni Other _____

OTHER QUESTIONS

8. Is the student transferring from another state, district, or school?

If yes, please provide location and name of school:

9. Has the student received schooling/education in a language(s) other than English? If YES, which language(s)?

10. In what language do you prefer to receive communication from the school?

11. In what language would you prefer to communicate with school staff?

12. Is there anything else we should know about how to best serve your child?

Signature of Parent or Guardian:

Date:

Translator:

Language:

Date:

Lawrence A. Sanchez
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Student Dental Examination Verification Form

Upon initial enrollment in a district or charter school, New Mexico Administrative Code (NMAC) 6.12.13 requires schools to verify student records of dental examination. This rule also allows for an informed opt-out process based on parent or guardian understanding of the risks associated with not having a dental examination.

Belen Consolidated Schools is dedicated to promoting the health of our students. We recognize oral health care is essential for general wellbeing and can have a significant impact on overall health. According to the [Centers for Disease Control and Prevention](#) (CDC), tooth decay is one of the most common chronic diseases of childhood in the United States. Left untreated, it can cause pain and infections that may lead to problems with everyday activities like eating, talking, playing, and learning. Routine oral health care such as dental visits, daily oral hygiene, healthy eating and consuming of water can help prevent tooth decay and other oral health conditions.

Student Name: _____

Student ID: _____

Please check the applicable response below:

- I confirm that my child has received a dental examination within the past calendar year.
- My child has not received a dental examination within the past year. I understand the risks associated with my child not receiving a dental examination, and I request a waiver allowing my child to be enrolled. If checked, this signed document may serve as the Student Dental Examination Waiver as defined by NMAC 6.12.13.

Parent/Guardian Signature: _____

Date: _____

Are you interested in learning more about oral health resources for your child? Please contact your School Nurse, or the New Mexico Department of Health, Office of Oral Health at 505-827-0837.