ARLEE SCHOOL DISTRICT 8J

Update or New Student Registration

Last Name	First Name	Middle Name	Grade	Age	Date of birth	Sex (M or F)	Social Security #

Mailing Address:

Physical Address if not same as above:

County of Residence: (chk. one) _____Missoula _____Lake _____Sanders _____Other

(Circle one) Are you living with PARENT, PARENTS, RELATIVE, LEGAL GUARDIAN, OTHER_____

Parent/Guardian Name *(This is the name of the student's legal guardian/s including people given documented educational responsibility for the child)*	Household phone # (land line)	Name of step-parent living in your household	step-parent's phone #	Student's cell phone #

CELL PHONE (Mom/female guardian):_____ (Dad/male guardian_____

WORK PHONE (Mom/female guardian):_____ (Dad/male guardian_____

E-Mail Address (Mom/female guardian):_____ (Dad/male guardian_____

(By listing the above e-mail addresses, you are approving school-related e-mails delivered to your e-mail addresses.)

Would you like to receive text messages to receive information from the school ?(yes or no)_____

In the case of divorced/separated parents, who is the custodial parent? *(This person has legal custody of the student)*

_____. *(School should have court documents on file.)*

The following information is on the parent/legal guardian that the child does ***NOT*** *live with:* ***(Unless the school has court documents on file stipulating otherwise, the school cannot deny any parent listed on the birth certificate access to their child or the child's records.)***

Name:	*Mailing Address:*	*City / Zip*	*Cell Phone*

By listing the following emergency contact people, you are giving them permission to pick up your child from school. If there are one or more on this list you do NOT want picking up your child at school, please note below. ***If you'd like to list more, please use a separate sheet of paper.***

Emergency Contacts:

			May this person pick up your child from school?
1st Contact:	Phone:	Relationship:	**Yes or No**
2nd Contact:	Phone:	Relationship:	**Yes or No**
3rd Contact:	Phone:	Relationship:	**Yes or No**

Physician: Phone:

Health problems or allergies we should know about?_____

Military Connected Status: Circle one if student is a dependent of a member of:

01: The United State Military (Army, Navy, Air Force, Marines or Coast Guard)

02: Active Duty National Guard

03: Active Duty Reserve Force of the US Military

04: Transitioning out of Active Duty to National Guard or Reserves

RACE/ETHNICITY **Two part question:**

Answer BOTH questions.

1. Is this student Hispanic or Latino? (Choose only one)

- ☐ No, not Hispanic or Latino
- ☐ Yes, Hispanic or Latino (A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)

2. What is the student's race?

(Regardless of how you answered the first question, choose one or more.)

- ☐ American Indian or Alaska Native (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
- ☐ Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ Black or African American (A person having origins in any of the black racial groups of Africa.)
- ☐ Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Check one below if American Indian:

_____NATIVE AMERICAN, ENROLLED _____NATIVE AMERICAN, NOT ENROLLED

If an <u>enrolled</u> Native American in a federally recognized Tribe, what Tribe/s are you <u>enrolled</u> in?_____

If <u>not enrolled</u>, but a Tribal descendant, which Tribe are you affiliated with?_____

_____

<u>If you are a Tribal descendant</u>, please check the degree of descendency:

_____**1st generation** ____**2nd generation** _____**greater than 2nd**

Information considered Directory Information may occasionally be released.

Please sign here if you do **NOT** wish Arlee Joint School District to release information such as my student's name, photos and awards received.

_____ _____

Signature Date

In accordance with Senate Bill 40, please choose:

[_] Opt in / [_] Opt out for Missing Child photo in AIM (the OPI Student Information System)

(Photos will only be used if a student is identified as a missing child.)

Please mark all of the programs your child may have been enrolled in previously:

_____Title I _____Special Education _____Speech

I have read the information contained on this registration form and completed the information to the best of my knowledge. I understand that this information is to be used while my child is enrolled at Arlee Schools.

_____ _____ _____

Signature of person completing form Relationship Date

Arlee Elementary School
Joint District #8
72220 Fyant Street
Arlee, Montana 59821
Phone: 406.726.3216
Fax: 888.315.4651

Date: _____

Authorization to Release Student Records

I, _____, hereby request and authorize the release of any and all pertinent records (including Special Education, psychological testing, social and emotional testing, standardized test data, speech/language, achievement, health and immunization records and Title/Chapter 1) for the following student(s) to be released to the above school:

Name	Birthdate	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I UNDERSTAND ALL INFORMATION TO BE RELEASED IS OPEN TO MY INSPECTION AND REVIEW.

Name and address of previous school:

Name: _____

Address: _____

City, State and Zip: _____

_____

Parent/Guardian Signature

Medical Treatment Authorization for Arlee Schools

Student: _____ Grade: _____

Parent/Guardian: _____

Telephone Home: _____ Work: _____ Alternate: _____

Address: _____

Health & History:

Has this student had any of the following:

	Yes	No		Yes	No	
1.	_____	_____	Chronic or recurrent illness?	10. _____	_____	Frequent headaches, convulsions, dizziness or fainting?
2.	_____	_____	Hospitalizations?	11. _____	_____	Heat exhaustion, heat stroke, etc?
3.	_____	_____	Surgery?	12. _____	_____	Any illness lasting over a week?
4.	_____	_____	Missing organs (eye, kidney, etc.)?	13. _____	_____	Mononucleosis or anemia?
5.	_____	_____	Allergy to medications?	14. _____	_____	Asthma?
6.	_____	_____	Problems with heart or blood pressure?	15. _____	_____	Epilepsy?
7.	_____	_____	Chest pain with exercise?	16. _____	_____	Diabetes?
8.	_____	_____	Dizziness or pain with exercise?	17. _____	_____	Glasses or contact lenses?
9.	_____	_____	Concussion or unconsciousness?	18. _____	_____	Dental braces, bridges, plates?

Does this student have a history of any of the following:

	Yes	No	
19.	_____	_____	Has this student had a neck injury?
20.	_____	_____	Has this student had a knee injury?
21.	_____	_____	Has this student had a knee surgery?
22.	_____	_____	Has this student had an ankle injury?
23.	_____	_____	Has this student had any other serious joint injuries?
24.	_____	_____	Has this student had broken bones (fractures)?
25.	_____	_____	Has this student had other serious illnesses or injuries? Please describe on back of this sheet.
26.	_____	_____	Is there any history of family or genetic disease?
27.	_____	_____	Has any family member died suddenly at less than 40 years of age as a result of an accident?
28.	_____	_____	Has any family member had a heart attack at less than 55 years of age?
29.	_____	_____	Uncomfortably short of breath after running 1/2 mile (2 times around the track)?

Other Health Information:

30. _____ _____ Is this student taking medication? If so, please explain on the back what condition the medication is treating.

31. What is the date of the last tetanus shot this student had? _____

Authorization:

I/We **DO** or **DO NOT** (circle your choice) give permission for authorized personnel of the school to seek medical attention for our child from a licensed medical doctor and/or treatment facility in the event the child is injured or becomes ill. In granting permission, I/we accept full financial responsibility for all costs associated with treatment(s) and hold the school and all its agents harmless from all liability associated with the treatment. If I/we do not give permission for authorized personnel of the school to get medical treatment for our child, then I/we accept full responsibility for the consequences to our child. NOTE: Without authorization, your child's participation may be restricted.

Signature of Parent or Guardian: _____ Date: _____

Dear Parent/Guardian:

We are trying to make the after school transition time run smoothly. We have decided that it would be helpful to know your child's(ren's) after school plans. These plans will be followed unless a note is sent to school telling us otherwise. If a note is sent to school it must be turned into the office first thing in the morning. If changes need to be made to an after school plan, please call the office BEFORE 2:00 pm to ensure that the note is delivered on time. Below is an example of how the form should be filled out. Please complete the form and return to school

Please call 726-3216, ext. 1, with any questions

Thank You!

My Child, Johnny Smith, who is in Mr. Jones' classroom will be doing the following after school unless I/We send a note stating otherwise.

Will Ride the bus after school.

If your child rides the bus, what bus number? 5

MY CHILD'S AFTER SCHOOL PLAN

My Child,_____, who is in _____ classroom will be doing the following after school unless I/We send a note stating otherwise.

Will _____ after school.

If your child rides the bus, what bus number? _____

_____ _____

Parent/Guardian Signature Date