

Hope Academy of Public Service

GENERAL STUDENT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

SSN: _____ Current Grade: _____ Birth date: _____ Age: _____

Gender: M or F

Ethnicity (check one):

____ Hispanic
____ Non-Hispanic

Primary Race (check only one):

____ American Indian/Alaska Native
____ Asian
____ Black
____ Hispanic
____ Native Hawaiian/Other Pacific Islander
____ White

Additional Race (check all that apply):

____ American Indian/Alaska Native
____ Asian
____ Black
____ Hispanic
____ Native Hawaiian/Other Pacific Islander
____ White

Pre-School Participation:

A- ARKANSAS BETTER CHOICE H- HEADSTART O- OTHER E- EVEN START NA- NOT
APPLICABLE
P- PRIVATE SCHOOL EC- EARLY CHILDHOOD C- 21ST CENTURY COMMUNITY LEARNING PS- PUBLIC
SCHOOL PRE-SCHOOL

Is this student a twin (or a triplet, quadruplet, etc.)? Yes No

Last School Attended (If not in Hope School District): _____

Phone Number: _____ Address: _____

Has this child been expelled from school in any other school district or is the child a party to an expulsion proceeding? _____

Is this child a dependent of an active or reserve member of a branch of the United States Armed Services? Yes
No

If so please select the branch of service:

____ Active Duty-US Army	____ Active Duty-US Air Force	____ Active Duty-US Navy	____ Active Duty-Marines
____ Active Duty-Coast Guard	____ Reserves-US Army	____ Reserves-US Air Force	____ Reserves US Navy
____ Reserves-US Marines	____ National Guard-US Army	____ National Guard-Air Force	____ Parents serve in multiple branches

Office Use Only:

Entry Date: _____ Entry Code: _____ Residency: _____ Curriculum: _____ SP: _____ GT: _____ 504: _____
Student Discipline Record: _____ Previous Academic Record: _____ ACTAAP Test Score: _____ Attendance: _____
Universal Screening Data _____ Teacher Comment: _____

As each item is received please check off and attach documentation

PARENT/GUARDIAN INFORMATION

Living with:

A-Alone F- Father Only T- Foster Parent P- Both Parents D- Father & Stepmother
E- Mother & Stepfather G-Grandparents L-Legal Guardian H-Homeless M-Mother Only

Do you prefer to receive correspondence in English or Spanish? _____

Parents/Guardians Name: _____ **Language Spoken at**
home: _____

Spouse Name: _____

Home Phone Number: _____ **Cell Phone Number(s):** _____

Mailing Address: _____ **Home Address:** _____

Resident County: _____

Parent/Guardian Workplace 1: _____ **Parent/Guardian Workplace 2:** _____

Work Number: _____ **Work Number:** _____

Email Address: _____ **Email Address:** _____

EMERGENCY CONTACT INFORMATION

Only the ones listed below will be allowed to check out the student.

Contact 1 Name: _____ **Phone Number:** _____ **Relationship:** _____

Contact 2 Name: _____ **Phone Number:** _____ **Relationship:** _____

Contact 3 Name: _____ **Phone Number:** _____ **Relationship:** _____

Contact 4 Name: _____ **Phone Number:** _____ **Relationship:** _____

TRANSPORTATION

[] CAR [] BUS ADDRESS: _____ BUS # _____

Will the student be going to a sitter/daycare? _____

Caregiver or Center Name: _____

Phone Number: _____

List other children attending Hope Public Schools in the family home and their present grade(s):

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

MEDICAL INFORMATION

Family Doctor: _____ Phone
Number: _____

Does student take medication(s)/use inhalers? ☐ Yes ☐ No

If yes, indicate the type of
medication(s): _____

Has student been diagnosed/classified as ADD/ADHD by a licensed professional? ☐ Yes ☐ No

If yes, please attach a copy of the evaluation/report confirming diagnosis.

Does student have any health problems that the teacher and school nurse should know about such as allergy to bee or wasp sting, asthma, diabetes, epilepsy, hearing problems, sickle cell disease, etc.? ☐ Yes ☐ No

If yes, please explain in
detail: _____

Does student wear eyeglasses or contacts? ☐ Yes ☐ No

May this information be shared with the appropriate staff involved with your child? ☐ Yes ☐ No

Does student have Medicaid? ☐ Yes ☐ No Medicaid #: _____

Does student have ARKids First? ☐ Yes ☐ No ARKids #: _____

I, the undersigned, do hereby authorize officials of Hope Public School District to contact directly the persons named on this enrollment forms and I do authorize the named physicians to render such treatment as may be deemed necessary in an emergency for heath of said child. In an event physician(s), other persons named on this form, or parents cannot be contacted, the officials are hereby authorized to take whatever action is deemed necessary in their judgment for the heath of aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation of said child.

Parent/Guardian Signature: _____

Date: _____

