CHAMBERLAIN SCHOOL DISTRICT ENROLLMENT FORM

2026-27 Chamberlain Elementary

Student #: _____ Bus #: _____ Grade_____

STUDENT INFORMATION-PLEASE PRINT

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

Suffix: Jr/ Sr/ Other _____ Sex: M or F Date of Birth: _____/_____/_____ State of Birth: _____ Grade: _____

Home Phone: _____ Parent Cell Phone: _____ Parent Cell Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: (if different from above) _____ City: _____ Zip: _____

Has the family moved in the past 3 years for agricultural purposes? ☐ Yes ☐ No

ETHNICITY/RACE:

Is this student Hispanic/Latino? ☐ Yes ☐ No

What is the student's race? ☐ American Indian or Alaskan Native ☐ Asian American ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White (Caucasian)

Language Survey (To meet State/Federal requirements, all questions must be answered):

1. What is the language most frequently spoken at home? _____
2. Which language did your child learn when he/she first began to talk? _____
3. What language does your child most frequently speak at home? _____
4. What language do you most frequently speak to your child? _____

SPECIAL SERVICES INFORMATION:

Does this student receive special education services? ☐ Yes ☐ No

Does this student have a current 504 Plan? ☐ Yes ☐ No *If yes, please indicate if related to* ☐ Academics ☐ Health

STUDENT PRIMARILY LIVES WITH:

☐ Both Parents ☐ Mother/Stepfather ☐ Father/Stepmother ☐ Mother Only ☐ Father Only

☐ Foster Parents ☐ Relative (Relationship to Student): _____ ☐ Other: _____

PRIMARY PARENT/GUARDIAN INFORMATION (PARENTS/GUARDIANS THAT THE STUDENT LIVES WITH):

Legal Guardian: ☐ Yes ☐ No

Primary Parent/Guardian Name: _____ Relationship to Student: _____

IF EMPLOYED--Employer:(REQUIRED) _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Email Address: (Required) _____

Primary Parent/Guardian Name: _____ Relationship to Student: _____

IF EMPLOYED---Employer:(REQUIRED) _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Email Address: _____

Home Address: (if different from above) _____ CityState: _____ Zip:_____

Mailing Address: (if different from above) _____ City: _____ Zip: _____

Please list any brothers/sisters living in the PRIMARY home *that attend* Chamberlain Public Schools.

Student Name: _____ GRADE_____
Student Name: _____ GRADE_____
Student Name: _____ GRADE_____
Student Name: _____ GRADE_____
Student Name: _____ GRADE_____

If a parent is not allowed to pick up the child COURT DOCUMENTATION must be provided to the office prior to the first day of attendance. If documentation is not provided, we cannot deny parents the right to pick up their own child.

SECONDARY PARENT/GUARDIAN INFORMATION

Legal Guardian: ☐ **Yes** ☐ **No** **Duplicate Mailings:** ☐ **Yes** ☐ **No**

Secondary Parent/Guardian Name: _____ Relationship to Student: _____

Home Address (Street): _____ Apt/Building: _____

City: _____ State: _____ Zip: _____

Mailing Address *(if different than home address)*: _____ City: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Employer: _____ Email Address: _____

EMERGENCY CONTACTS Can not use the same people and #'s as the Primary Parent/Guardian

Name: _____ Relationship to Student: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Name: _____ Relationship to Student: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

IN ADDITION TO EMERGENCY CONTACTS, please list individuals who have permission to leave messages or pick up your student.

1.) Name: _____ Phone # _____

2.) Name: _____ Phone # _____

3.) Name: _____ Phone # _____

4.) Name: _____ Phone # _____

Chamberlain Public Schools
McKinney-Vento Act
Student Information

This questionnaire is intended to address the McKinney-Vento Act. Your answers will help the administration determine residency documents necessary for enrollment of this student.

Signature of Parent/Legal Guardian _____ **Date**_____

Print Student Name_____

Where does the student stay at night? *Check One*

A. _____	In a shelter.	E. _____	in another location that is not appropriate for people (e.g. an abandoned building)
B. _____	In a motel/hotel	F. _____	Temporarily with more than one family in a house, mobile home, or apt. (because the family does not have a place of its own)
C. _____	In a car	G. _____	Other (in an arrangement that is not fixed, regular, and adequate and is not described by the other choices)
D. _____	At a campsite	H. _____	None of the above. **STOP** if you checked this answer, you do not need to complete the remainder of this form. Please submit this to the building principal's office. **Please continue if you checked A-G.**

School_____

Student Name_____M_____F_____

Birth Date _____Grade Level_____

Name of Parent(s)/Legal Guardian(s)_____

Address_____Home Phone_____

Cell Phone_____

List Additional Age Children Living with you

Name	**Age**	**Grade Level**

STUDENT NAME: _____ **DATE OF BIRTH:** _____ **GRADE:** _____

Medical Alert/Health Conditions (Asthma, Allergies, etc.) ***Parents/Guardians are responsible for providing full details on any medical condition to the school.***

Medical Conditions: _____

Daily Medications: _____

ALLERGIES: _____

Do Allergies Require Emergency Medications? _____

I understand that it is my responsibility to notify the school of any change in my address, phone number and/or my child's health information.

I authorize Chamberlain Public Schools to seek emergency medical treatment for my student if I cannot be reached in an emergency.

Parent Signature: _____ **Date:** _____

I verify that I have read, or will read, and familiarize myself with the Parent/Student Handbook and the 22-23 truancy policy . **Available at http://chamberlain.k12.sd.us** Parent Signature _____ Date: _____

By signing this document, I verify the above information (including health information) on this form is correct to the best of my knowledge including the address above being our place of residence.
I understand that it is my responsibility to notify the school of any change in my address, phone number and/or my child's health information.

If you do not want your students picture or work displayed on any Chamberlain School District 7-1 Web Page (www.cubs.org/start) or social media please notify the building Principal. If a picture or student work is displayed it will not be identified and will be done so in compliance with Chamberlain School District 7-1 Web Publishing School Board Policy IIBG

My child has my permission to accompany class/activity groups on education and activity trips _____YES_____NO

Parent Signature: _____ **Date:** _____

OUT SIDE HEALTH SCREENING:

Eye Screening is done for kindergarten, 1st, 3rd, 5th, 7th and 9th grade, by the SD Lions Foundation. The information obtained from this vision screening is preliminary only and does NOT constitute a complete exam or diagnosis of vision problems. You will receive results from the Lions "KIDSIGHT" Preschool Vision Program only if your child is being recommended for a full eye exam. It is the responsibility of the parent/guardian to arrange a complete eye exam if your child has been referred because of the screening. SD Lions Foundation will not be held accountable for any errors of commission, omission, or another misdiagnosis.

Hearing Screening is done for kindergarten, 1st, 3rd, and 5th grade by the SD School of Deaf. The information obtained from the hearing screening is only preliminary and your child may be referred for more testing. If your child is being referred for a more in-depth hearing exam, it will be the responsibility of the parent/guardian to arrange for the hearing exam to be done. South Dakota School of Deaf will not be held accountable for any errors of commission, omission, or another misdiagnosis.

By signing, you give SD Lions Foundation permission to do eye screenings and the SD School of Deaf permission to perform a hearing screening.

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

ELEMENTARY:

COUGH DROPS:

I authorize my child to take over the counter/non-prescription cough drops while at school and relieve the school district and personnel of all responsibility. I understand that the school district and individuals involved will not be held liable for any adverse effects of the cough drops. I understand that my child shall possess only the number of cough drops necessary for school hours or the school event or activity for one day.

Students are prohibited from transferring, delivering or receiving any medications to or from another student. All violations will result in confiscation of the medication and subject student(s) to discipline in accordance with the district's progressive disciple policy. Students who use medication for purposes other than for its intended use will be disciplined and no longer be allowed to carry and self-administer medications.

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