

STROTHER PUBLIC SCHOOL - Enrollment Form

PLEASE PRINT IN BLUE OR BLACK INK

SCHOOL USE	STUDENT ID# _____		ENTRY DATE _____		CODE _____ B.O.A. _____		GRADE _____		
	____ Birth Certificate		____ Proof of Residency		____ Transfer Approved		____ CAR		
	____ Immunizations		____ 506 Form/CDIB Card		____ Special Services		____ BUS # _____		
STUDENT INFORMATION	STUDENT LEGAL NAME - LAST			FIRST		MIDDLE		AGE	Entering Grade
	Name Student Goes By (first and last)			GENDER M _____ F _____		DATE OF BIRTH		BIRTHPLACE - City, State	
	SOCIAL SECURITY NO.		ETHNICITY: (check 1) Hispanic/Latino _____ Not Hispanic/Latino _____		RACE: (check all that apply) ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native Tribal Affiliation? Yes No ☐ Asian ☐ Native Hawaiian/other Pacific Islander				
	MAILING ADDRESS- E-911 /PO Box, etc.			APT#/LOT#		CITY/ZIP		HOME TELEPHONE (not cell#)	
	PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING)							RESIDENT OF STROTHER SCHOOL DISTRICT? YES _____ NO _____	
	IS YOUR RESIDENCE 1.5 MILES OR MORE FROM STROTHER SCHOOL? YES _____ NO _____							IF NO, WHAT DISTRICT? _____	
								TRANSFER SUBMITTED? Y N	
	TRANSPORTATION (A.M.): CAR BUS B# _____				TRANSPORTATION (P.M.): CAR BUS B# _____ TO:				
	FROM: HOME _____ OTHER _____				HOME _____ OTHER _____				
	WEARS GLASSES? YES NO		DOES STUDENT RECEIVE SPECIAL SERVICES? YES _____ NO _____ Type: _____						
DOES THIS STUDENT QUALIFY FOR: (circle) SOONER CARE OR MEDICAID? YES _____ NO _____ If yes, ID# _____									
STUDENT LIVES WITH: (CIRCLE) Both Parents / Mother Only / Father Only / Joint Custody / Parent & Step-Parent / Other _____									
NOT ALLOWED PICKUP (Documentation required for non-custodial parent)									
PARENT INFO	*Guardian #1= LEGAL PARENT/GUARDIAN to receive notices of attendance, eligibility and grade reports via email/Parent Portal.								
	GUARDIAN #1 / CUSTODIAL PARENT					GUARDIAN #2			
	NAME _____					NAME _____			
	RELATIONSHIP _____					RELATIONSHIP _____			
	CELL PH. _____					CELL PH. _____			
	PLACE OF EMPLOYMENT _____					PLACE OF EMPLOYMENT _____			
WORK PH _____ FEDERAL EMPLOYEE _____					WORK PH _____ FEDERAL EMPLOYEE _____				
*E-MAIL (see above) _____					E-MAIL _____				
EMERGENCY	EMERGENCY CONTACTS - OTHER THAN PARENT/GUARDIAN LISTED ABOVE								
	Name _____ Relationship _____ Cell # _____ Home # _____								
PRIOR ED.	Name _____ Relationship _____ Cell # _____ Home # _____								
	Strother Public Schools - Grade _____ Year _____ OR, complete next line								
SIBLINGS	LAST SCHOOL ATTENDED: _____ City _____ State _____ Grade _____								
	HAS STUDENT EVER BEEN RETAINED? Y or N If yes, which grade? K 1 2 3 4 5 6 7 8 9 10 11 12								
SIBLINGS	OTHER CHILDREN IN FAMILY								
	NAME		AGE	GENDER	GRADE	STROTHER SCHOOL (Y/N)			
	NAME		AGE	GENDER	GRADE	STROTHER SCHOOL (Y/N)			

In the event that an emergency arises during school, an effort will be made to contact the parents or guardians immediately. Permission is granted to the school officials to provide the needed emergency treatment to the student prior to his admission to the medical facilities. Permission is also granted to the attending physician at the Seminole Hospital to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above named student. If said physician is not able to contact me, the treatment necessary for the best interest of the above name student may be given.

PARENT/GUARDIAN WITH LEGAL CUSTODY _____ DATE _____

School Year: _____

Health Information Form

Strother Public Schools

STUDENT _____

DATE OF BIRTH _____

DOCTOR'S NAME _____ DOCTOR'S NUMBER _____

Check the box(s) if your child has a history of any medical problems, illness, or allergies.

___ Asthma-Triggered by? _____

___ Seizures-Describe: _____ How long since last seizure? _____

___ Heart-Condition Describe: _____

___ Diabetes-if yes Type 1 ___ or Type 2 ___

___ Stomach Problems explain: _____

___ Hearing and or Vision Problems: ___ Glasses ___ Contact Lenses ___ Hearing Aid

___ Professional diagnosis of ADD/ADHD: Medications: Diagnosing Physician: _____

___ Congenital Illness- Describe: _____

___ Anxiety/Depression: _____ History of Panic Attacks: _____

___ Allergies Food Allergy: Types of food: _____

___ Insect Sting Allergy: Types of insects: _____

___ Allergy to Medication: _____

___ Latex Allergy: _____

___ Other Allergies: _____

___ Epi-Pen: Which Allergy? _____

Any other specific health issue which might affect his/her school experience? _____

Please indicate if you would like any of the following incidental medications to be administered to your child if first aid is needed during the school day:

___ Hydrocortisone, triple antibiotic ointment, antiseptic spray, and calamine lotion

___ If you would not like any of these medications used for your child due to allergies, etc. Please indicate here: _____

___ None. I would not like any of these medications administered to my child.

If your child has a medical condition that requires medication to be taken at school, a Medication Administration Record must be completed by the parent/guardian. Forms are available at the school office. Medication should be brought to school in the original OTC/prescription container.

By signing this form, I consent the information on this form may be shared with appropriate personnel for health and educational purposes. I give permission for my child to be screened by designated personnel for hearing, vision, and dental problems.

Parent Signature _____