BILLINGS PUBLIC SCHOOLS
PK-12 ENROLLMENT FORM ……

OFFICE USE ONLY	Student State ID:	Birth Certificate: ❑ Yes ❑ No	Immunizations Received: ❑ Yes ❑ No	School Entry Date: School Name:

I. Student Information

1.(LEGAL NAME ONLY) Last Name | First | Middle | Suffix (Jr, II, III)

2. Other name(s) used previously (AKA):

3. Nickname:

4. Grade:

5. Birth Date: / /

6. Birth Place (city, state)

7. Gender ❑ Male ❑ Female

8. Is student a US Citizen? ❑ Yes ❑ No

9. Previously enrolled in School District #2 ❑ Yes ❑ No
if yes: Date:_____ Grade: ____
School:

10. Previously enrolled in a Montana School ❑ Yes ❑ No
if yes: Date:_____ Grade: _____
School:

11. Is student Hispanic or Latino? ❑ Yes ❑ No

13. Primary Phone ( )

12. Race (Check all that apply):
❑ White
❑ Native Hawaiian or Other Pacific Islander
❑ Black or African American
❑ Asian
❑ American Indian or Alaska Native
Tribal Affiliation: _____
(Please attach 506 form with enrollment form)

14. Language(s) Spoken at Home

15. Student's Primary Language

16. Home Address | City | State | Zip Code

17. Mailing Address (if different than home address) | City | State | Zip Code

II. Parent and Emergency Contact Information

18. PARENT/GUARDIAN

❑ Lives with student
❑ Student's Legal Guardian
❑ Mailing List
❑ Receive BPS news by email

Last Name | First Name

Relation to Student | Email Address | Place of Employment

Home Address (if different than Box 16) | City | State | Zip Code

Mailing Address (if different than home address) | City | State | Zip Code

Primary Phone ( ) | Work Phone ( ) | Cell Phone #1 ( )

19. PARENT/GUARDIAN OTHER

❑ Lives with student
❑ Student's Legal Guardian
❑ Mailing List
❑ Receive BPS news by email

Last Name | First Name

Relation to Student | Email Address | Place of Employment

Home Address (if different than Box 16) | City | State | Zip Code

Mailing Address (if different than home address) | City | State | Zip Code

Home Phone ( ) | Work Phone ( ) | Cell Phone #1 ( )

20. LOCAL EMERGENCY CONTACT (Other than Parent/Guardian)

Last Name | First Name

Relation to Student | Primary Phone ( ) | Work Phone ( ) | Cell Phone ( )

Home Address | City | State | Zip Code

21. ADDITIONAL CONTACT

Last Name | First Name

Relation to Student | Primary Phone ( ) | Work Phone ( ) | Cell Phone ( )

Home Address | City | State | Zip Code

Please attach separate sheet if more contact information is needed

OFFICE ONLY Student Name: _____ Grade: _____ Teacher/Counselor: _____ Student ID: _____

III. Siblings

22. Complete this section only if applicable. Include only siblings who are currently in Grade PK-12 in Billings Public Schools

Sibling #1 full name:	Grade:	School Name:
Sibling #2 full name:	Grade:	School Name:
Sibling #3 full name:	Grade:	School Name:
Sibling #4 full name:	Grade:	School Name:

IV. Previous Schools

	Name of School	City	State	Grades
23. Last Elementary School Attended				
24. Last Middle School Attended				
25. Last High School Attended				
26. Any additional schools attended in the past year				

OFFICE USE ONLY	Records Requested: / /	Records Received: / /

V. QUESTIONS FOR PARENTS

27. Has student ever received service from or been involved in: (check all that apply):

❑ Special Education ❑ Title 1 ❑ Reading Tutor ❑ Section 504 ❑ Speech Therapy

❑ English 2nd Language ❑ Behavior Management ❑ Counseling ❑ Gifted Program

❑ Other:

28. Have you been engaged in migrant work in the last three years? ❑ Yes ❑ No

29. Has student immigrated to the United States ❑ Yes*
*if yes: date first enrolled in US School: ❑ No

30. Has this student ever been under long term suspension or been suspended from school? ❑ Yes ❑ No

31. Legal Bindings: Please list any legal binding information, including restraining orders, custody agreements that are pertinent to this student and his/her safety: (copy of the legal documentation is required).

32. Is there any other information that would help us better serve your student?

33. Dependent of Active Duty Military Member: Is this student the dependent of an active duty military member? If so:

Name of Military Member: _____

Relationship: _____

❑ The US Military (Army, Navy, Air Force, Marines, or Coast Guard)
❑ Active Duty National Guard
❑ Active Duty Reserve Force of the US Military
❑ Transitioning out of Active Duty to National Guard or Reserve

All information provided in sections I to V are complete and accurate to the best of my knowledge.

✘ _____ _____
Parent/Guardian signature (required) *Date*

OFFICE ONLY Student Name: _____ Grade: _____ Teacher/Counselor: _____ Student ID: _____

Health and Medical Information

❑ **Allergies to**: ❑Bee Sting ❑Food ❑ Environment ❑Latex ❑Medication ❑ Other

Name of Medication(s): _____

❑ ***needs medication at School ❑ takes medication at home

Describe reaction and intervention: _____

List other allergies:

❑ **Asthma:**
Name of medication(s) _____
❑ ***needs medication at School ❑ takes medication at home ❑ carries inhaler on person ❑ inhaler in school office

❑ **Attention Deficit Disorder:**
Name of Medication(s) _____
❑ ***needs medication at School ❑ takes medication at home ❑ diagnosed but no medication

❑ **Diabetes:** ❑ *Insulin dependent/ needs school program set up ❑*Self manages snacks, diet, testing, coverage

❑ **Headaches:**
Name of medication(s)

❑ **Seizures:**
Name of medication(s) _____
❑ ***needs medication at School ❑ takes medication at home ❑ history of seizure but not currently on medication

❑ **Other Medications:** ❑ ***needs medication at School ❑ takes medication at home Diagnosis: _____

Name of medication(s)

❑ **Hearing Concerns:**
(Please explain)

❑ **Vision Concerns:**
(Please explain)

❑ **Physical Restrictions:**

❑ *Uses mobility aide (wheelchair, walker, crutches, etc.)

❑ *Restricted because of _____

❑ Must avoid this/these activities _____
(Doctor's letter is required for some P.E. adaptations)

❑ **Other:** Describe health history (operations, serious accidents, and serious illness)

_____

_____

_____

_____

Diseases/Conditions: If known, please indicate the year of the disease/condition when applicable:

❑ Chicken Pox ❑ Measles(Rubella) ❑ Mumps ❑ Rubella (3 day) ❑ Scarlet Fever ❑ Sinusitis
❑ Eczema ❑ Whooping Cough ❑ Heart Disease ❑ Rheumatic Fever ❑ Kidney/Bladder Disorder ❑ Congenital Condition

❑ Other(please describe):

Hospital Sign Off: In case of an emergency, I authorize medical/dental care:

Please indicate hospital of choice: ❑ Billings Clinic ❑ St. Vincent's ❑ Either

Doctor's name:	**Dentist's name:**

***NOTE:** All items will require notification of the school nurse. If medication is needed, the parent must complete a medication authorization form before the first dose of medication can be given at school. This health concern information may be shared with school personnel as necessary to benefit the health and safety of this student and others. Please keep school staff informed as to changes to the information so the student's records can be updated as needed.

_____ _____

Parent/Guardian signature (required) *Date*

OFFICE ONLY Student Name: _____ Grade: _____ Teacher/Counselor: _____ Student ID: _____