



# BILLINGS PUBLIC SCHOOLS PK-12 ENROLLMENT FORM .....

<b>OFFICE USE ONLY</b>	Student State ID:	Birth Certificate: <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunizations Received: <input type="checkbox"/> Yes <input type="checkbox"/> No	School Entry Date: School Name:
<b>I. Student Information</b>				
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 <input type="checkbox"/> Male <input type="checkbox"/> Female
8. Is student a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No				
9. Previously enrolled in School District #2 if yes: Date: _____ Grade: _____ School: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No		11. Is student Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Previously enrolled in a Montana School if yes: Date: _____ Grade: _____ School: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No		13. Primary Phone ( ) ( )
12. Race (Check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native Tribal Affiliation: _____ <small>(Please attach 506 form with enrollment form)</small>				
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	

<b>II. Parent and Emergency Contact Information</b>							
<b>PARENT/GUARDIAN</b>	<input type="checkbox"/> Lives with student <input type="checkbox"/> Student's Legal Guardian <input type="checkbox"/> Mailing List <input type="checkbox"/> Receive BPS news by email	18. 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 ( ) ( )	
<b>PARENT/GUARDIAN OTHER</b>	<input type="checkbox"/> Lives with student <input type="checkbox"/> Student's Legal Guardian <input type="checkbox"/> Mailing List <input type="checkbox"/> Receive BPS news by email	19. 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 ( ) ( )	
<b>20. LOCAL EMERGENCY CONTACT (Other than Parent/Guardian)</b>	Last Name		First Name				
	Relation to Student		Primary Phone ( ) ( )		Work Phone ( ) ( )		
	Home Address		City	State	Zip Code		
<b>21. ADDITIONAL CONTACT</b>	Last Name		First Name				
	Relation to Student		Primary Phone ( ) ( )		Work Phone ( ) ( )		
	Home Address		City	State	Zip Code		
<b>Please attach separate sheet if more contact information is needed</b>							

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
<b>23.</b> Last Elementary School Attended				
<b>24.</b> Last Middle School Attended				
<b>25.</b> Last High School Attended				
<b>26.</b> Any additional schools attended in the past year				

<b>OFFICE USE ONLY</b>	Records Requested:    /    /	Records Received:    /    /
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### 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 2<sup>nd</sup> Language     
  Behavior Management     
  Counseling     
  Gifted Program

Other:

<p><b>28.</b> Have you been engaged in migrant work in the last three years?      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	<p><b>29.</b> Has student immigrated to the United States      <input type="checkbox"/> Yes*                  *if yes: date first enrolled in US School:      <input type="checkbox"/> No</p>
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<p><b>30.</b> Has this student ever been under long term suspension or been suspended from school?      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	<p><b>32. Is there any other information that would help us better serve your student?</b></p>
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**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).

**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.

X \_\_\_\_\_ Date \_\_\_\_\_  
 Parent/Guardian signature (required)

OFFICE ONLY Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher/Counselor: \_\_\_\_\_ Student ID: \_\_\_\_\_

## Health and Medical Information

<input type="checkbox"/>	<b>Allergies to:</b> <input type="checkbox"/> Bee Sting <input type="checkbox"/> Food <input type="checkbox"/> Environment <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Other  Name of Medication(s): _____ <div style="text-align: center;"><input type="checkbox"/> *needs medication at School    <input type="checkbox"/> takes medication at home</div>  Describe reaction and intervention: _____  List other allergies: _____
<input type="checkbox"/>	<b>Asthma:</b> Name of medication(s) _____ <div style="text-align: center;"><input type="checkbox"/> *needs medication at School    <input type="checkbox"/> takes medication at home    <input type="checkbox"/> carries inhaler on person    <input type="checkbox"/> inhaler in school office</div>
<input type="checkbox"/>	<b>Attention Deficit Disorder:</b> Name of Medication(s) _____ <div style="text-align: center;"><input type="checkbox"/> *needs medication at School    <input type="checkbox"/> takes medication at home    <input type="checkbox"/> diagnosed but no medication</div>
<input type="checkbox"/>	<b>Diabetes:</b> <input type="checkbox"/> *Insulin dependent/ needs school program set up <input type="checkbox"/> *Self manages snacks, diet, testing, coverage
<input type="checkbox"/>	<b>Headaches:</b> Name of medication(s) _____
<input type="checkbox"/>	<b>Seizures:</b> Name of medication(s) _____ <div style="text-align: center;"><input type="checkbox"/> *needs medication at School    <input type="checkbox"/> takes medication at home    <input type="checkbox"/> history of seizure but not currently on medication</div>
<input type="checkbox"/>	<b>Other Medications:</b> <input type="checkbox"/> *needs medication at School <input type="checkbox"/> takes medication at home    Diagnosis: _____  Name of medication(s) _____
<input type="checkbox"/>	<b>Hearing Concerns:</b> (Please explain) _____
<input type="checkbox"/>	<b>Vision Concerns:</b> (Please explain) _____
<input type="checkbox"/>	<b>Physical Restrictions:</b> <input type="checkbox"/> *Uses mobility aide (wheelchair, walker, crutches, etc.)  <input type="checkbox"/> *Restricted because of _____  <input type="checkbox"/> Must avoid this/these activities _____ <div style="text-align: center;">(Doctor's letter is required for some P.E. adaptations)</div>
<input type="checkbox"/>	<b>Other:</b> Describe health history (operations, serious accidents, and serious illness)  _____ _____ _____ _____
<b>Diseases/Conditions:</b> If known, please indicate the year of the disease/condition when applicable: <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles(Rubella) <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella (3 day) <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Sinusitis <input type="checkbox"/> Eczema <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Heart Disease <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Kidney/Bladder Disorder <input type="checkbox"/> Congenital Condition <input type="checkbox"/> Other(please describe): _____	
<b>Hospital Sign Off: In case of an emergency, I authorize medical/dental care:</b> Please indicate hospital of choice: <input type="checkbox"/> Billings Clinic <input type="checkbox"/> St. Vincent's <input type="checkbox"/> Either	
<b>Doctor's name:</b> _____	<b>Dentist's name:</b> _____

OFFICE ONLY Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Teacher/Counselor: \_\_\_\_\_

Student ID: \_\_\_\_\_

**\*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

# Billings Public Schools

## HOME LANGUAGE SURVEY

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex:  Male  Female

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Date: \_\_\_\_\_

1. Was your child born in the United States?  Yes  No  
 If yes, in which state? \_\_\_\_\_  
 If no, in what other country? \_\_\_\_\_

2. Has your child attended any school in the United States for any three years during their lifetime?  Yes  No  
 If yes, please provide school name(s), state, and dates attended:  
 Name of School \_\_\_\_\_ State \_\_\_\_\_ Dates Attended \_\_\_\_\_  
 Name of School \_\_\_\_\_ State \_\_\_\_\_ Dates Attended \_\_\_\_\_  
 Name of School \_\_\_\_\_ State \_\_\_\_\_ Dates Attended \_\_\_\_\_

3. What language is spoken by you and your family most of the time at home? \_\_\_\_\_

4. If available, in what language would you prefer to receive communication from the school? \_\_\_\_\_

5. Please check if your child is:  
 A.  Native American Indian C.  Native Pacific Islander  
 B.  Alaska Native D.  Native U.S. Virgin Islander

6. Is your child's first-learned or home language anything other than English?  Yes  No

**If you responded "Yes" to question number 6 above, please answer the following questions:**

7. What language did your child learn when he/she first began to talk? \_\_\_\_\_

8. What language does your child most frequently speak at home? \_\_\_\_\_

9. What language do you most frequently speak to your child? (Father) \_\_\_\_\_  
 (Mother) \_\_\_\_\_

10. Please describe the language understood by your child. (Check only one)  
 A.  Understands only the home language and no English.  
 B.  Understands mostly the home language and some English.  
 C.  Understands the home language and English equally.  
 D.  Understands mostly English and some of the home language.  
 E.  Understands only English.

\_\_\_\_\_  
 Parent or Guardian's Signature

\_\_\_\_\_  
 Date

OFFICE USE ONLY			
Student ID #	Date Distributed	Date Received	