



HOME *of the* BUCCANEERS

MILFORD SCHOOL DISTRICT NEW STUDENT REGISTRATION

Welcome to Milford School District! We are excited that you are registering your child with us and we will work hard to ensure that we provide the best education possible. The school registration process requires a parent or legal guardian to visit the school where your child will attend and finalize a packet of information and provide copies of the documents listed below. A student may not begin school without a completed packet and all of the documents on file.

- Copy of Parent/Guardian Driver's License or Government Issued Identification Card
- Proof of Residence – Acceptable documents include:
 - Housing Lease
 - Mortgage Statement
 - Utility Bill (gas, electric, water, etc.) The bill must list the address where services are rendered and list the person registering the child.
- Birth Certificate (copy)
- Recent Report Card/Course Transcript
- Proof of Immunizations/Shot Records
- The following documentation if applicable:
 - Legal Documents concerning Custody
 - Individualized Education Plan (IEP)
 - 504 Plan
 - Withdrawal Letter/Document from the previous school

You may call the school in advance to schedule a time to register. Please bring the above information when you register your student. If you do not know which school your child should be attending please use the school locator link on the registration section of the district website.

Kindergarten Registration

All children entering Kindergarten will be tested. Your student must be 5 years old on or before August 31st of this year in order to attend Kindergarten. Please contact the Morris Early Childhood Center (302-422-1650) to schedule a registration and screening time for your student. You must bring your student with you for the registration.

MILFORD SCHOOL DISTRICT

STUDENT INFORMATION

School:

Today's Date:

Student's Name:

Date of Birth:

Grade:

Age:

Address:

Gender:

Race:

City:

State:

Zip:

Ethnicity: Hispanic Origin?

Parent/Guardian #1

Lives w/

Parent/Guardian #2

Lives w/

Name:

DOB:

Name:

DOB:

Home Phone:

The above phone number will receive all automated calls from the district including school closings/delays and school announcements.

Home Phone:

The above phone number will receive all automated calls from the district including school closings/delays and school announcements.

Cell Phone:

Cell Phone:

Home Address:

Home Address:

City:

State:

Zip:

City:

State:

Zip:

Email Address:

Email Address:

Place of Employment:

Place of Employment:

Work Phone:

Ext:

Work Phone:

Ext:

There **are no** legal documents concerning the custody of my child. I understand that in the absence of legal documents, the father/mother listed on the birth certificate and emergency contacts will be allowed to visit and/or pick up my child from school.

There **are** legal documents concerning the custody of my child. Legal custody documents are provided at the time of registration. In the absence of legal custody documents I understand that the father/mother listed on the birth certificate and emergency contacts will be allowed to visit and/or pick up my child from school.

Has this child previously attended any Delaware Public or Charter School?

Year:

School:

Was this child ever retained?

Year:

School:

Does your child have an IEP, Speech, or 504 plan?

No, you may **NOT** use my child's picture for external publications.
(ie. School Website, Newspapers, Television, news, etc.)

Name of School that student is transferring from:

Address of School that student is transferring from:

The information presented on this form is factual. I understand that any misinformation regarding custody and residency may affect this students' enrollment in the Milford School District.

Parent/Guardian Signature: _____ Date: _____

MILFORD SCHOOL DISTRICT
APPLICATION FOR BUS TRANSPORTATION OR ADDRESS CHANGE

Home Address:

City:

Zip:

If you have moved, please note previous address:

Home Phone:

Cell Phone:

Work Phone:

Student Name:

School:

Pick-Up Address:

City:

Drop-Off Address:

City:

Student Name:

School:

Pick-Up Address:

City:

Drop-Off Address:

City:

Student Name:

School:

Pick-Up Address:

City:

Drop-Off Address:

City:

Student Name:

School:

Pick-Up Address:

City:

Drop-Off Address:

City:

****If either the “Pick-up” or “Drop-off” address is not at the home address, please give the Caregiver’s Information below.****

Name:

Phone #:

Parent / Guardian Signature

Printed Parent / Guardian Name

Date

For Office Use Only

Please Attach ID and Scan with ID Attached

**Milford School District
Request for Student Records**

To: _____

Prior School Name

Address

School Phone Number Fax Number

Please fax the following items:

- _____ Birth Certificate
- _____ Immunization Records
- _____ Last Report Card
- _____ Withdrawal Grades
- _____ Demographic Sheet from School
- _____ IEP/504 Plan
- _____ Other (_____)

I authorize and request that the records be sent to the Milford School District for:

Student Grade Date of Birth

Please mail or fax records to:

Please include:

- Cumulative Records
 - Complete Transcript including grades and credits up to withdrawal date (High School)
 - Previous Report Cards (Elementary and Middle School)
- Explanation of grading system
- Test results: Standardized, Aptitude/Interest & Psychological
- Health & Immunization Records
- Special Education Records or Accommodation Plans, including IEP and evaluations on reports (Special Education Audit File)
- Any other data that will help us provide satisfactory adjustments to our school

Records will be used for professional purposes only and will be kept confidential.

Parent or Guardian Signature

Date



DEPARTMENT OF EDUCATION

Townsend Building
401 Federal Street Suite 2
Dover, Delaware 19901-3639
<http://education.delaware.gov>

Mark A. Holodick, Ed.D.
Secretary of Education
(302) 735-4000
(302) 739-4654 - fax

Delaware Department of Education Home Language Survey

Date: _____

School: _____

The Delaware Department of Education requires schools to determine the language(s) spoken at home by each student. The information provided will only be used to determine whether your student is eligible to begin the English as a Second Language process and will not be used for immigration matters or reported to immigration authorities.

| Student Information | | | |
|---------------------|--|---|--|
| First Name: | | Country of birth: | |
| Last Name: | | Date of entry in the US: | |
| Birthdate: | | Date student first enrolled in a US school: | |

Circle grades your child attended in US schools

PK K 1 2 3 4 5 6 7 8 9 10 11 12

How many total months has the student been enrolled in a US school? _____

1. What language did your child first learn?

Language: _____ | Dialect: _____

2. What language does your child most often use at home?

Language: _____ | Dialect: _____

3. What languages do you most often speak to your child?

Language: _____ | Dialect: _____

4. What language(s) other than English are spoken in your home?

Language: _____ | Dialect: _____

5. What language would you prefer to receive information from your school?

Language: _____ | Dialect: _____

Parent Name

Parent Signature

Date

LEA : Please have all families complete this home language survey at the student's initial enrollment in school. This form must be signed and dated by the parent or guardian and kept in the student's file. (If a language other than English or Non-US English is listed on questions 1-3, the LEA must continue with a records review, step 2 of the English learner identification process.)



2022 – 2023 MILITARY-CONNECTED YOUTH STUDENT INFORMATION UPDATE FORM

All Delaware public schools starting with the 2016 – 2017 school year are required to annually identify enrolled students who are “military-connected youth” pursuant to 14 **DE Admin. Code** 932, 14 **Del.C.** Chapter 1, §122 (b)(28), 10 U.S.C. §101(d) (2014), and the reauthorized Every Student Succeeds Act (2015), 20 U.S.C. 6301 et seq. in order to possibly provide your student with additional supports and services if needed.

Please read the following statements and check the appropriate box below.

- If you are a parent or a step-parent, only check the box that specifically applies to you, your duty status and branch of the United States armed forces.
- If you are a parent or a step-parent meeting the definition of box one or two, and there is an immediate family member residing in the same household that meets the definition of box three, then both boxes should be checked.
- If your student is not a “military-connected youth”, please check the fourth box, “Non-Applicable”.

PARENTS OR STEP-PARENTS

☐ “**Active Duty**” - I am a parent or step-parent who is an “**active duty**” member of the Armed Forces (United States Army, United States Navy, United States Air Force, United States Marine Corps, or United States Coast Guard) pursuant to 10 U.S.C. §101(d) (2014), and the reauthorized Every Student Succeeds Act (2015), 20 U.S.C. 6301 et seq.

☐ “**Active Duty/Recently Retired/Reserves/Identified as a Disabled Veteran/Killed in Action**” - A parent or step-parent *residing in the same household*, who is on active duty, serving in the reserve component, identified as a disabled veteran, killed in action, or recently retired (within 18 months prior to September 30 of the current school year) from a branch of the United States armed forces. Such branches consist of the United States Army, United States Air Force, United States Marine Corps, United States Navy, National Guard, United States Coast Guard, National Oceanic and Atmospheric Administration or the United States Public Health Service pursuant to 14 **DE Admin. Code** 932, 14 **Del.C.** Chapter 1, §122 (b)(28), 10 U.S.C. §101(d) (2014).

IMMEDIATE FAMILY MEMBER OR ANY OTHER PERSON RESIDING IN SAME HOUSEHOLD

☐ “**Active Duty/Recently Retired/Reserves/Identified as a Disabled Veteran/Killed in Action**” - An immediate family member, including a sibling or any other person *residing in the same household*, who is on active duty, serving in the reserve component, identified as a disabled veteran, killed in action or recently retired (within 18 months prior to September 30 of the current school year) from a branch of the United States armed forces. Such branches consist of the United States Army, United States Air Force, United States Marine Corps, United States Navy, National Guard, United States Coast Guard, National Oceanic and Atmospheric Administration or the United States Public Health Service pursuant to 14 **DE Admin. Code** 932, 14 **Del.C.** Chapter 1, §122 (b)(28), 10 U.S.C. §101(d) (2014).

☐ **NON-APPLICABLE**

Student Name: _____ Grade: _____

School Name: _____

Homeroom Teacher Name: _____

Please return this form to your student’s homeroom teacher on or before Monday, September 19, 2022.

**DELAWARE DEPARTMENT OF EDUCATION
TITLE I, PART C
Agricultural Work Survey**

English

Dear Parent/ Guardian,

Date: _____

In order to serve your child, _____, the _____ District/Charter School is
(Insert District/Charter School Name)
helping the State of Delaware identify students who may qualify to receive additional education and support services.

The information provided below will be kept confidential with in the Department of Education and will be used for planning purposes only. Please answer the following questions and return this form to your child's school.

1. In the past 3 years, has your family changed from: a) one school district to another; b) one state to another state; c) another country to the U.S.?

_____ YES _____ NO

If "NO," do not complete the remainder of this survey. If "YES," please continue.

2. Was the reason for this change **to look for or to accept** a job in an agricultural or fishing activity such as those listed below? Answer this question even if you have a different type of job now.

_____ YES _____ NO

If "YES," please circle all that apply if you or your husband/wife, or someone in your household has worked with, on, or in a:

| | | | |
|---------------|--------------------------|--|--|
| Farm | Chicken processing plant | Dried or dehydrated fruits/spices | Plant nursery/greenhouse |
| Dairy | Processing meat/fish | Sod farms | Tree growing or harvesting |
| Ranch | Cranberry bogs | Meat or food packing plant | Food processing |
| Cannery | Fresh/frozen juices | Mushrooms | Pet food processing |
| Chicken house | Fishery | Planting, picking, or packing fruits, vegetables, seeds, or nuts | Cleaning, weeding or preparing land for planting |

Please add any other agricultural or fishing work/activity that you or your husband/wife or someone in your household has performed:

Please list all children **ages 3-21 years old** in the home, including those not enrolled in school:

| First / Last name | Date of Birth | Age | Grade | School |
|-------------------|---------------|-----|-------|--------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Parent/Guardian: _____

Address: _____ Apt. No. _____ City: _____ Zip: _____

Phone: _____ Best time to be reached _____ AM / PM Alternate or cell phone number: _____

DISTRICTS: All **ORIGINAL** copies of the survey with "**YES**" responses for **BOTH** questions 1 and 2 **MUST** be submitted to the Delaware Department of Education **Migrant Education Program Office** within 10 days of the student's enrollment by **State Mail Code N510** or by U.S. Postal Service to **35 Commerce Way, Suite 1, Dover, DE 19904**. A COPY of this form must be retained in the student's file to document compliance with the Title I, Part C federal program requirements.



MILFORD SCHOOL DISTRICT

Last Name:

Student's Name:

Date of Birth:

Grade:

Age:

Address:

Gender:

Race:

City:

State:

Zip:

Ethnicity: Hispanic Origin?

Student Resides with:

Relationship:

Custody Papers on File:

Bus # to:

Bus # from:

Transportation: Other:

Day Care: Name/Phone #:

Parent/Guardian #1

Parent/Guardian #2

Name:

DOB:

Name:

DOB:

Home Phone:

Home Phone:

Cell Phone:

Cell Phone:

Home Address:

Home Address:

City:

State:

Zip:

City:

State:

Zip:

Email Address:

Email Address:

Place of Employment:

Place of Employment:

Work Phone:

Ext:

Work Phone:

Ext:

Parent/Guardian will be contacted first. If unavailable, the following emergency contacts will be contacted.

| Name | Relationship | Home Phone | Cell Phone | Work Phone |
|------|--------------|------------|------------|------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Insurance Company:

Medical Insurance Information

ID Number:

Group:

Medicaid #:

Other Insurance Information:

I give the School Nurse permission to talk to my child's medical Doctor/Dentist, as needed: Yes

No

Physician:

Phone:

Dentist:

Phone:

SCHOOL EMERGENCY PROCEDURES

Your schools have adopted the following procedures that will normally be followed in caring for your child when he/she becomes sick or injured at school. In extreme emergencies, the school will seek immediate medical care. In case of emergency and/or need of medical or hospital care:

1. The school will call the home. If there is no answer,
2. The school will call the Mother's, Father's or Guardian's place of employment. If there is no answer,
3. The school will call the other telephone number(s) listed and the physician.
4. If none of the above answer, the school will call an ambulance, if necessary to transport the student to a local medical facility.
5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
6. The school will continue to call the parents, guardians or physician until one is reached.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia which may be carried out based on the medical judgment of the attending physician.

I verify that all the above information is correct. This information may be shared with school personnel on a "need to know" basis. Please contact the school if any of the above information changes.

Parent/Guardian Signature: _____ Date: _____

Please complete and return: The State of Delaware requires that all students have an emergency card on file in the School Nurse's Office.



MILFORD SCHOOL DISTRICT HEALTH QUESTIONNAIRE

Today's Date: _____

Student's Name: _____

Birthdate: _____

Sex: _____

Grade: _____

Please list all other persons living in your child's household:

| Name | Birthdate | Relationship to Child |
|------|-----------|-----------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

PLEASE ANSWER ALL QUESTIONS LISTED BELOW

Has your child had any of the following? Please check and explain.

| | | | |
|-------------------|--------------------------|-------------------------|--------------------------|
| Asthma | <input type="checkbox"/> | Bone or Muscle Problems | <input type="checkbox"/> |
| Chicken Pox | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | Frequent Ear Infections | <input type="checkbox"/> |
| Kidney Problems | <input type="checkbox"/> | Frequent Sore Throats | <input type="checkbox"/> |
| Bleeding Problems | <input type="checkbox"/> | Headaches | <input type="checkbox"/> |
| Stomach Problems | <input type="checkbox"/> | Fainting / Blackouts | <input type="checkbox"/> |

Please explain any problem(s) checked above: _____

Allergies to Medicines, Food, Insect Bites, Bee Stings, etc.? Please list: _____

What medicine does your child take for allergic reactions? _____

Hospitalizations? List dates and reason: _____

Surgery? List dates and type: _____

Serious Illnesses/Injuries? List dates and type: _____

Has your child had any immunizations since kindergarten? Yes ☐ No ☐

If yes, list type and date: _____

Does your child visit the dentist regularly? Yes ☐ No ☐

If yes, list type and date: _____



MILFORD SCHOOL DISTRICT

Does your child have a hearing problem? Yes ☐ No ☐

If yes, list problem: _____

Does your child have a vision problem, wear glasses or contacts? Yes ☐ No ☐

If yes, list problem and date of last eye exam: _____

If he/she wears glasses or contacts, when was the last new prescription? _____

Does your child take any **daily** medications? Yes ☐ No ☐

If yes, list medicine and illness/condition: _____

Will medicine need to be given at school? Yes ☐ No ☐

If yes, please see school nurse to sign permission forms.

Is your child presently being treated for an illness? Yes ☐ No ☐

If yes, list illness and medicine: _____

Has your child's development been normal? Yes ☐ No ☐

(Walking, Talking, Toilet Training, Physical Growth and Development)

If no, list reasons: _____

Were there any problems with the pregnancy and delivery of this child? Yes ☐ No ☐

If yes, list problems: _____

Has your child had any emotional upsets or changes in his/her life? Yes ☐ No ☐

(Moves, Separation, Divorce of Parents, Death, etc.)

If yes, please explain: _____

Are you concerned about your child's behavior? Yes ☐ No ☐

If yes, please explain: _____

Does your child have any other health problems you are concerned

or that the school should be aware of? Yes ☐ No ☐

If yes, please explain: _____

Please list any serious health problems of this child's mother, father, grandparents, sisters or brothers:

Please list the date of your child's last physical exam and the name of the doctor:

Additional Comments/Concerns: _____

Milford School District

Permission for Use of Over -The- Counter Medications during the Current School Year!

Name of Student: _____ Date: _____

Does your child have allergies to medicine, food, latex or insect bites: Yes ____ No ____

If yes: To What? _____ What Happens? _____

Treatment: _____

As parent/guardian, I give my permission for the above named student to have the following medications administered by the school nurse during the current school year. I understand that he/she will be checked by the school nurse and the medications will be administered if indicated following the nurse's assessment. Please check only those medications you wish to be given to your child when needed.

_____ Anbesol/Oragel (mouth Pain)

_____ Anti fungal Cream

_____ Benadryl Lotion (anti- itch)

_____ Blistex (lip ointment)

_____ Burn Ointment/ Spray

_____ Caladryl Lotion

_____ Calamine Lotion (anti-itch)

_____ Carmex (mouth lesions)

_____ Chapstick (lip balm/ Vaseline)

_____ Contact lens solution/saline/ rewetting

_____ Cough drops

_____ Eye Wash solution

_____ Hydrocortisone cream

_____ Medicated Powder/Baby Powder

_____ Mineral Ice (muscle pain)

_____ Sting Kill (Insect Sting relief)

_____ Throat Spray(Chloreseptic Spray)

_____ Triple Antibiotic Ointment

_____ Vicks (vapor rub)

_____ Advil/ Ibuprofen

_____ Tylenol/Acetaminophen

_____ Tums (antacid)

_____ Benadryl

My child may use hand sanitizer: ____ YES ____ NO My child may need help with hand sanitizer ____ YES ____ NO

If your child requires prescription medication during the school day, please contact your child's school nurse
ex. Medication for: ADHD, ADD, Diabetes, Seizures, Asthma medications (inhalers, nebulizer medication), Epi-pens, Benadryl, etc.

Medical Diagnosis: _____

My child takes medication at home: (before school/after school)

Name of Medication/s: _____

- Students may not carry medications during the school day without Parent/Doctor/School Nurse permission. Paperwork must be completed and on file in the nurses office.

 PARENT/GUARDIAN SIGNATURE _____ Date: _____

Dear Parent or Guardian,

According to Delaware Code, Title 14, section 131; a child is not permitted to enter into school with acceptable evidence of immunization. If your child is a new enterer* to Delaware public schools he or she will not be permitted to enroll without an immunization record. Please see below for children of active duty members of the uniformed services. Delaware law requires the following for entry to public school. If these items are not provided to the school within 14 CALENDAR DAYS from the date below your child will be denied entry into school.

1. IMMUNIZATIONS:

- Four (4) or five (5) doses of DPT or DTAP, or a combination thereof. A fifth dose is not required if the fourth dose is given after the fourth birthday.
- Three (3) or four (4) doses of the polio (OPV or IPV) vaccine. A fourth dose is not required if the third dose is given after the fourth birthday.
- Three (3) doses of Hepatitis B vaccine.
- Two (2) doses of measles, mumps and rubella vaccine, MMR, (first dose after the age of 12 months, second dose after the fourth birthday).
- Two (2) doses of Varicella (chicken pox), or a written disease history by a licensed healthcare provider. For new enterers, two doses are required.
- Students entering 9th grade must have 1 dose of Tdap (adult booster) and 1 dose of meningococcal. (compliance grades 9-12)

2. PHYSICAL EXAM:

- A physical examination by a physician, nurse practitioner, or physician's assistant within the last two
- (2) years for all new enterers. A second health examination is required for all students entering 9th
- grade. Examinations completed no more than two years prior to entry into 9th grade will be accepted.

3. TUBERCULOSIS SCREENING:

- Written results from either a TB risk assessment, a Tuberculosis skin test (Mantoux, PPD), or a Quantiferon TB Gold test, within the last twelve (12) months.

4. LEAD TEST:

- All kindergarten and preschool students must show proof of a blood lead test, completed anytime after one (1) year of age.

If you enroll your child over the summer, please be aware that if appropriate documentation is not provided for any of the above requirements within 14 days of the date below, the date of exclusion will start on the first day of school.

If your child is transferring to our school from another school in the state of Delaware we assume he or she currently complies with all the above requirements. However, if for any reason your child does not meet all of the above requirements, your student will also have 14 days from the date of this form to comply with regulations.

Military families: Children of active duty members of the uniformed services will have 30 days from the date of enrollment to comply with the above immunizations requirements.

All documents should be turned in to the school as soon as possible. BY STATE LAW, FAILURE TO PROVIDE THESE DOCUMENTS WILL RESULT IN EXCLUSION FROM SCHOOL.

- A new enterer is defined as a child entering a Delaware public school for the first time, including but not limited to foreign exchange students, immigrants, students from other states and territories and children entering from non-public schools.

Please sign below to acknowledge receipt of this information.

Parent/Guardian Signature

Date

Student's Name

Grade

Milford School District

Temporary Special Education Placement for Transfer Students (30 days maximum)

Student Name _____ School: _____ Date: _____

Parent/Guardian: _____ Birthdate: _____

Address: _____ Grade: _____

City _____ State _____ Zip _____ Phone #: _____

Documentation of Phone Conference:

School: _____ Phone #: _____

Date: _____ Person: _____ Title: _____

Classification: _____

Time Per Day: Special Ed Time: _____ Regular Ed Time: _____

Setting: _____

| Special Education | | Related Services | |
|-------------------|-------------|------------------|------------|
| Subjects | Grade Level | Service | Time/Freq. |
| | | | |
| | | | |
| | | | |
| | | | |

Date of Last Reevaluation: _____

Other Information: _____

Related Services: _____

Temporary Placement:

Classification: Same as Above

Time Per Day: _____

Setting: _____

Special Education & Related Services: _____

Signature of Parent/Guardian: _____



Delaware McKinney-Vento Student Residency Questionnaire

This **Student Residency Questionnaire** is intended to address the McKinney-Vento Act. Your answers will help the school personnel determine residency documents necessary for enrollment of this student. Information provided on this form is confidential.

Name of Student: _____ D.O.B.: _____ Grade: _____ ☐ Male ☐ Female

Name of Current School: _____ Name of Last School: _____

Is your current address a **temporary** living arrangement? Yes ☐ No ☐

If you answered 'YES', please complete all questions on this form.

If you answered 'NO', please skip questions 1 – 4 and complete the bottom section.

1. Do you live in any of these following situations?

☐ Sharing the housing of other persons due to: (check one)

☐ Loss of housing, economic hardship or a similar reason (example: evicted, lost job, etc.)

Explain: _____

☐ Long-term, cooperative living arrangement to save money or a similar reason

☐ Other (please specify): _____

☐ In a motel, hotel, campground or similar setting due to: (check one)

☐ Lack of alternative adequate accommodations,

Explain: _____

☐ A convenient living arrangement or waiting for apartment or house to be ready

☐ Other (please specify): _____

☐ In an emergency or transitional shelter such as a domestic violence shelter or a homeless shelter or transitional housing or other shelter

☐ Have a primary nighttime residence that is a place not designed for or ordinarily used as a regular sleeping accommodation for humans

☐ In a car, park, public space, abandoned building, substandard housing, bus or train station, or similar setting

☐ None of the above

2. How long do you anticipate living at this location? _____

3. The student lives with:

☐ Parent(s) or legal guardians(s)

☐ Relative(s), friend(s), or other adults(s) who are not the parent or the legal guardian

☐ Alone with no adults

4. Please list the name and ages of any children living with you that you have guardianship of:

A. _____ C. _____

B. _____ D. _____

I am the parent/legal guardian of _____, who is of school age and who is seeking enrollment in the school district.

I understand that presenting a false record of falsifying records is an offense under Federal and state laws and enrollment of the child under false documents subjects the person to liability for tuition and other costs.

Printed Name: _____

Signature: _____ Date: _____ Email: _____

Address: _____

Phone Number with Area Code: _____ Emergency contact Phone Number with Area Code: _____

(Rev 8/2019)