Drew Elementary School

Student Registration Form

Student Name: _____ **Former School** _____

Entering Grade: _____ **Date of Birth:** _____ **Gender:** F M **Race:** _____

Home Address: _____

Mother's Name: _____ **Cell Phone:** _____

Email: _____

Place of Employment: _____ **Work Phone:** _____

Father's Name: _____ **Cell Phone:** _____

Email: _____

Place of Employment: _____ **Work Phone:** _____

Student Lives With (circle): Both Parents Mother only Father only Legal Guardian

We cannot enforce custody without the judgement signed by the judge. We must have a copy on file in the office.

Support Services (circle if apply): 1508/Resource Section 504/IAP Speech

Known Medical Conditions: _____

Allergies: No Yes List: _____

Emergency Contacts/Checkout Authorization: If your child is ill, injured, or needs care, we will contact the parents/legal guardians. We will only contact these if we cannot reach the parents/legal guardians.

Name: _____ **Phone:** _____ **Relation:** _____

Name: _____ **Phone:** _____ **Relation:** _____

Name: _____ **Phone:** _____ **Relation:** _____

AM Transportation (circle): Car Bus (#_____)

PM Transportation (circle): Car Bus (#_____) Daycare_____ After-School

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Any special circumstances we need to be aware of: _____

_____

_____

Drew Elementary School

Parent/Guardian Acknowledgement

2026–2027 School Year

Homeroom Teacher: _____

I acknowledge that I have received or have access to the Drew Elementary Student Handbook and understand it is my responsibility to review the handbook with my child and abide by the policies and procedures outlined within.

The handbook includes information regarding:

- Ouachita Parish Pupil Progression Plan
- Attendance and Truancy Policy
- Crisis Management Plan
- School Insurance
- Child Nutrition Program
- Published Student Information Release (PMI)
- Technology Acceptable Use Policy
- Cell Phone & Electronic Device Policy
- Louisiana Ivy Daniels Act Information

Scan QR to accessStudent Handbook

I understand that these policies may be updated during the school year in accordance with state law, district policy, or school procedures.

I also give permission for my child's image and/or work to be used for school-sanctioned publications and activities in accordance with the Published Student Information (PMI) policy unless I notify the school otherwise.

Student Name: _____

Grade: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Louisiana Student Residency Questionnaire

(Form Must Be Included In School Enrollment Packet)

Date:_____ LEA:_____ School Name:_____

Student Name:_____ ID#:_____ Gender: Male / Female

Address:_____ Phone:_____

Last School Attended:_____ Current Grade:_____ Date of Birth_____

Parent/Guardian/Adult Caring for Student:_____ Relationship:_____

Disclaimer: This questionnaire is intended to address the McKinney-Vento Act. Your child may be eligible for additional educational services through Title I Part A, Title I Part C Migrant, Individuals with Disabilities Education Act (IDEA) and/or Title IX, Part A, Federal McKinney-Vento Assistance Act, 42 U.S.C.11435. Eligibility can be determined by completing this questionnaire. It is illegal to knowingly make false statements on this form. If eligible, students are to be immediately enrolled in accordance with Bulletin 741, section 341.

1. ☐YES ☐ NO Did the student receive McKinney Vento (Homeless) Services in a previous school district?
2. ☐YES ☐ NO Is the student's address a temporary living arrangement? (Note: If this is a permanent living arrangement or the family owns or rents their home, complete questions 6 & 7 and sign under item 12 and submit form to school personnel.)
3. ☐YES ☐ NO Is the temporary living arrangement due to loss of housing or economic hardship?
4. ☐YES ☐ NO Does the student have a disability or receive any special education-related services? (Check one)
5. Where is the student currently living? (Check all that apply.)
   - ☐ In an emergency/transitional shelter.
   - ☐ Temporarily with another family because we cannot afford or find affordable housing.
   - ☐ With an adult that is not a parent or legal guardian, or alone without an adult.
   - ☐ In a vehicle of any kind, trailer park or campground without running water/electricity, abandoned building or substandard housing.
   - ☐ Emergency Housing (i.e. FEMA Trailer or FEMA Rental Assistance)
   - ☐ In a hotel/motel. ☐ Other specific information:_____
6. ☐ YES ☐ NO Within the past 6 months, we worried whether our food would run out before we got money to buy more.
7. ☐ YES ☐ NO Within the past 6 months, the food we bought just didn't last, and we didn't have money to get more.
8. ☐ YES ☐ NO Does the student exhibit any behaviors that may interfere with his or her academic performance?
9. Would you like assistance with uniforms, student records, school supplies, transportation, other? (Describe):_____
10. ☐ YES ☐ NO Migrant – Have you moved at any time during the past three (3) years to seek temporary or seasonal work in agriculture (including Poultry processing, dairy, nursery, and timber) or fishing?
11. ☐ YES ☐ NO Does the student have siblings (brothers or sisters)? Note: Use back of page if more space is needed.

Name _____ School _____ Grade _____ DOB _____
Name _____ School _____ Grade _____ DOB _____
Name _____ School _____ Grade _____ DOB _____

12. The undersigned certifies that the information provided above is accurate

_____

Print Parent/Guardian/Adult Caring for Student's Name | Signature | Date

_____

(Area Code) Phone Number | Street Address | City | State | Zip Code

_____

Print School Contact Name | Title | Signature | Date

Homeless Liaison Use Only – Check All that Apply:

☐ Sheltered ☐ Doubled-Up ☐ Unsheltered/FEMA/Substandard ☐ Hotel/Motel Unaccompanied Youth: ☐ YES ☐ NO
☐ Sent Resources or made contact with POC for food insecurity

School Use Only:

☐ Free or Reduced Price Meals Form submitted/signed ☐ Copy Placed in Student's Cumulative Record

Revised 07/2026

LOUISIANA DEPARTMENT OF EDUCATION

Ivy Daniels Act

Parent/Guardian Acknowledgment Form

Student Name: _____

School: _____

Grade: _____

School Year: _____

Louisiana law requires public schools to provide information regarding the crime and consequences of unlawful dissemination or sale of images of another created by artificial intelligence as provided in R.S. 14:73.14 and unlawful possession of images of another created by artificial intelligences as provided in R.S. 14:73.14.1.

By signing below, I acknowledge that:

- I have received information regarding the Ivy Daniels Act (Act 782 of 2026).
- I understand the criminal, disciplinary, and financial consequences associated with unlawful dissemination, sale, and possession of images of another created by artificial intelligence.
- I have reviewed this information with my child.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____Date: _____

Student Signature (Optional): _____ _____ Date: _____

School Use Only
Date Received: _____
Received By: _____

FINAL 11/06

STATE OF LOUISIANA

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.

Name of School:			Grade:	
Student's Name: Last		First		M.I.
Student's Date of Birth:	Sex: ☐ M ☐ F		State or Country of Birth:	
Student's Mailing Address:	City:		State:	Zip Code:
Student's Physical Address:	City:		State:	Zip Code:

Name of Mother or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:

Name of child's pediatrician or primary care provider:	Names of medical specialists or special clinics caring for your child:

_____

Parent or Legal Guardian Signature Date

Please check the type of health insurance your child has: ☐ Private ☐ Medicaid/LaCHIP ☐ None

If your child does not have health insurance, would you like information on no cost health insurance? ☐ Yes ☐ No

In case of emergency—if parent or legal guardian cannot be reached—contact the following:

Name Complete Phone Number ( )

My child has a medical, mental, or behavioral condition that may affect his/her school day: ☐ No ☐ Yes (If yes, please complete Part 2.)

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.

❑ ALLERGIES

Allergy Type:

- ☐ Food (list food(s)) _____
- ☐ Insect sting (list insect(s)) _____
- ☐ Medication (list medication(s)) _____
- ☐ Other (list) _____

Reactions: (Date of last occurrence if yes.)

- ☐ Coughing (Date:) ☐ Hives (Date:) ☐ Rash (Date:)
- ☐ Difficulty breathing (Date:) ☐ Local swelling (Date:) ☐ Wheezing (Date:)
- ☐ Generalized swelling (Date:) ☐ Nausea (Date:) ☐ Other _____ (Date:)

Currently prescribed medications and treatments:

☐ Oral antihistamine(Benadryl, etc.) ☐ Epi-pen ☐ Other _____

❑ ASTHMA

Triggers: ☐ Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ ☐ Other (list) _____

Does your child experience asthma symptoms with exercise? ☐ No ☐ Yes

Symptoms:

☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Coughing ☐ Wheezing ☐ Other _____

Currently prescribed medications and treatments: _____

_____

Date of last hospitalization related to asthma _____ Date of last emergency room visit related to asthma _____

Does your child have a written asthma management plan? ☐ No ☐ Yes

Is peak flow monitoring used? ☐ No ☐ Yes

Name: _____ DOB: _____

❑ **DIABETES**

Currently prescribed medications and treatments:

☐ Insulin: ☐ Syringe ☐ Pen ☐ Pump
☐ Blood sugar testing
☐ Glucagon
☐ Oral medication(s) List medication(s) _____

Is special scheduling of lunch or Physical Education required? ☐ No ☐ Yes

❑ **SEIZURE DISORDER**

Type of seizure:

☐ Absence (staring, unresponsive) ☐ Complex Partial ☐ Generalized Tonic-Clonic (Grand Mal/Convulsive)
☐ Other (explain) _____

Physical Education Restrictions: ☐ No ☐ Yes

Medication(s): ☐ No ☐ Yes List medication(s) _____

Date of last seizure _____ Length of seizure _____

❑ **OTHER HEALTH CONDITIONS**

☐ Anemia ☐ ADD/ADHD ☐ Cancer ☐ Cerebral Palsy ☐ Chicken Pox ☐ Cystic Fibrosis
☐ Depression ☐ Digestive disorders ☐ Emotional/Psychological ☐ Juvenile Rheumatoid Arthritis
☐ Hemophilia ☐ Heart condition ☐ Physical disability ☐ Sickle Cell Disease ☐ Skin disorders
☐ Speech problems ☐ Other (explain)_____

Physical Education Restrictions: ☐ No ☐ Yes (explain): _____

Medication(s): ☐ No ☐ Yes List medication(s) _____

Special procedures required (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning): ☐ No ☐ Yes (explain):_____

Special diet required (i.e., blended, soft, low salt, low fat, liquid supplement): ☐ No ☐ Yes (explain): _____

Are there anticipated frequent absences or hospitalizations? No Yes
(explain):_____

❑ **VISION CONDITIONS**

☐ Contacts/glasses
☐ Other _____

❑ **HEARING CONDITIONS**

☐ Hearing aid(s)
☐ Other _____

❑ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**

Special school environmental adjustments of the school environment or schedule: ☐ No ☐ Yes (explain):_____

(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)

Special school environmental adjustments to classroom or school facilities: ☐ No ☐ Yes (explain):_____

(i.e., temperature control, refrigeration/medication storage, availability of running water)

Special safety considerations: ☐ No ☐ Yes (explain):_____

(i.e., special precautions in lifting, positioning, special transportation emergency plan, special safety equipment, special techniques for positioning, feeding)

Special assistance with activities of daily living: ☐ No ☐ Yes (explain):_____

(i.e., eating, toileting, walking)

PART 3: SCHOOL NURSE TO COMPLETE if parent/legal guardian indicates medical condition.

_____ _____
School Nurse Signature Date

Notes:

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE