MELROSE-MINDORO AREA SCHOOLS

ENROLLMENT/EMERGENCY INFORMATION

*SCHOOL YEAR*_____

Confidentiality Laws Upheld

Please complete and return to your child's school

Please print in black/blue ink only!! Do not bend or fold.

Student's Name_____DOB_____
Last *First* *Middle Name*

Place of Birth:_____
City *County* *State*

Address: _____ *Check One* M_____ F_____

_____ Home Phone: _____ Cell Phone:_____

Enrollment Date:_____ Grade_____ Class: (ex: 2005)_____

Previous School Attended:_____

Address:_____

Student prefers to be called:_____ Locker no._____ SSN:_____

Ethnicity: Is this student Hispanic or Latino? _____ No _____ Yes

Race: Please choose one of the following: ____ American Indian/Alaskan Native ____ Asian
____ Black/African American ____ Native Hawaiian/Pacific Islander ____ White

Child resides with: _____Father _____Mother _____Both _____Step Parent _____Foster Parent
(*Please check all that apply)* _____Other:_____

FAMILY INFORMATION

	FATHER	MOTHER
Name:		
Address:		
Township/County:		
Home Phone:		
E-Mail:		
Cell Phone:		
Employer:		
Work Phone:		
Work E-Mail:		

* if applicable **ADDITIONAL HOUSEHOLD INFORMATION** (Step-Parent, Foster Parent, Etc.)

Relationship to Student:		
Name:		
Address:		
Township/County:		
Home Phone:		
E-Mail:		
Cell Phone:		
Employer:		
Work Phone:		
Work E-Mail:		

Do you want all mailings sent to both parents if living at different address: ____ yes ____ no

If no please send to (circle one) mother father

If the parents are divorced, who has custodial rights? _____Mother _____Father _____Joint
_____Other_____

If there is a legal document restraining an individual(s) from having contact with your child, you must submit a copy of this document to Building Principal/Office in order for the restraint to be followed. The document must list the name(s) of the individual(s) restrained and the relationship to your child.

Other Children Living In Your Household

Full Name	DOB	Grade	Relationship

EMERGENCY INFORMATION

TO PROVIDE A SOUND HEALTH AND SAFETY PROGRAM AND TO PREVENT DELAYS IN YOUR CHILD CARE IN CASE OF INJURY OR ILLNESS, PARENTS ARE REQUESTED TO PROVIDE THE FOLLOWING INFORMATION:

In case of an emergency, please call me first: (Number in order of preference)
_____Mother _____Father _____Both _____Other:_____

List relatives or neighbors who will assume temporary care of your child if you cannot be reached:

Name	Relationship to Child	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

IN CASE OF EARLY DISMISSAL, MY CHILD SHOULD:_____
_____
_____

HEALTH INFORMATION

Does your child have any of the following health conditions?
_____Diabetes _____Heart Problems _____Asthma _____Allergies _____ADD/ADHD
_____Seizure Disorder _____Hearing Problems _____Visual Problems _____Skeletal Problems
Please Explain:_____
_____
Is your child on medication? ___Yes ___No What Medication?_____
Will your child require administration of this medication at school? _____ Yes_____ No
Times_____ Medical Order_____
Last time your child was seen by a doctor?_____
Does your student wear glasses? ____Yes ____No Is your child left handed? ____Yes ____No
Is your child in Special Education? ____Yes ____No If yes, explain_____
_____
Family Physician:_____ Phone:_____
Family Dentist:_____ Phone:_____
Hospital Preference:_____ Phone:_____

The above information may be shared as necessary.

In case of serious illness or injury and the school is unable to contact us, we authorize the school to call the physician indicated and follow his instruction. If the school cannot contact the physician above, the school may make whatever arrangements that seem necessary. The school district is not responsible for any medical expenses incurred on behalf of the student

*Are there any Special medical, or emotional needs that the school nurse and/of staff should be aware of?*_____

Signature of Parent/Guardian _____Date:_____