West Muskingum Local School District

Student Enrollment Data

Today's Date:_____Select one: Elementary (K-4) Middle School (5-8) High School (9-12) Grade: _____

Pupil's Full Name: _____ _____ _____
(first) (middle) (last)

Street Address:_____ Apt. No./Lot No/PO Box _____

City/Zip Code:_____Home Phone:_____County of Residence: (Select one) Muskingum Licking

Date of Birth: _____ City of Birth: _____ Gender: _____

Ethnic: (Select one) White Black Asian Multiracial* Native Hawaiian or other Pacific Islander American Indian or Alaskan Native

Is this student of Hispanic or Latino origin? ☐ YES ☐ NO

When the ethnic group is not provided by parent/guardian, per FY07 ODE reporting instructions, student will be reported as "multiracial".

STUDENT LIVES WITH: (Check one)

Father and Mother: ☐ Mother: ☐ Father: ☐ Mother and Stepfather: ☐

Father and Stepmother: ☐ Grandparent: ☐ Legal Guardian: ☐ Foster Parent: ☐

Father's Name_____Home Phone:_____ Cell _____

Father's home address, if different than child's _____

Father's Place of Employment_____Work Phone: _____

Mother's Name_____Home Phone:_____Cell _____

Mother's home address, if different than child's _____

Mother's Place of Employment_____Work Phone: _____

Student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard) ☐ NO ☐ YES

Student is a dependent of a member of the National Guard (Army National Guard or Air National Guard) ☐ NO ☐ YES

If you would like the teacher to correspond via email, list who will receive the email and the email address:

Name:_____Email address: _____

Copy of custody/guardianship papers must be provided at time of enrollment: If you are a grandparent, you must have a court approved Power of Attorney and/or Caretaker Authorization Affidavit on file prior to registering a student.

Agency (if under foster care): Name of agency: _____

Complete Address: _____

County Agency Located:_____Telephone:_____

Caseworker: _____

Is your child in any special classes? ☐ NO ☐ YES If yes, please mark which classes:

☐ Speech ☐ Learning Disability (L.D) ☐ Cognitive Disability (CD) ☐ Emotional Disturbance (ED) ☐ 504 Plan ☐ Title I ☐ Gifted

Other (i.e., special education services not listed)_____

NEW ENROLLMENT REGISTRATION

Please furnish copies of the following: Social Security Card, Immunization Records, and Birth Certificate from the Health Department (not hospital record).

Mother's Maiden Name:_____ Native Language _____

What type of kindergarten class did your child attend: ☐ Half Day ☐ All day every-other day ☐ Everyday

School Last Attended _____

Mailing Address: _____

_____Number of Younger Brothers _____Number of Older Brothers_____Number of Younger Sisters _____Number of Older Sisters

PHOTO/IMAGE RELEASE

_/ ***I grant permission to West Muskingum Local Schools to use the photo/image/likeness of my child in print or electronic publications. This agreement covers all images taken during the current school year.***

_/ ***I do not grant permission to West Muskingum Local Schools to use the photo/image/likeness of my child in print or electronic publications. This agreement covers all images taken during the current school year.***

IF NEITHER BOX IS CHECKED ABOVE, IT IS UNDERSTOOD PERMISSION IS GRANTED FOR WEST MUSKINGUM SCHOOLS TO USE PHOTO/IMAGE/LIKENESS OF CHILD IN MEDIA.

EMERGENCY MEDICAL AUTHORIZATION *For emergency use, list in order, starting with parent, the people to be called:*

Name	Relationship	Home Phone	Cell Phone	Work Phone	Other

Facts concerning your child's medical history to which a physician or school should be alerted: (medications being taken, physical impairments, allergies., etc.) _____

_____

Purpose: *To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached:*

Part I or Part II must be completed ***PART I (Permission to Consent to Treatment)***

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for administration of any treatment deemed necessary by:

(preferred physician) Dr. _____ *Telephone:* _____

(preferred dentist) Dr. _____ *Telephone:* _____

or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and the transfer of the child to: (preferred hospital) Telephone: _____ *or any hospital reasonably accessible.*

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Date: _____ ***Signature of Parent/Guardian:*** _____

************DO NOT COMPLETE PART II, IF YOU COMPLETED PART I************

PART II (Refusal to Consent)

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

_____

_____

_____

Date: _____ **Signature of Parent/Guardian:** _____

Office use only:

Teacher/Homeroom _____ Student ID# _____ Bus No. _____ Locker # _____ Comb # _____

(Revised August 7, 2018)