

Beatrice Public Schools
Student Enrollment Information
Page 1 of 5

Date of Enrollment: _____
Student ID #: _____

Teacher/Counselor: _____
Room: _____

STUDENT INFORMATION SECTION - Please Print

Student's Full Legal Name: _____
Last First Middle
Grade: ____ Gender: M F Social Security # _____ Birth Date: _____ State/Country of Birth: _____
Month/Day/Year
Resident Address: _____ Apt/Bldg: _____ City: _____ State: ____ Zip: ____
Student Cell Phone Number: _____ Student E-mail Address: _____

Ethnicity/Race

PART A

Is this student Hispanic/Latino? Yes No A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin, regardless of race.

PART B

Part A is about ethnicity, not race. No matter what you selected above in PART A **please continue to answer the following** by marking one or more boxes to indicate what you consider your student's race to be.

- American Indian or Alaskan Native A person having origins in any of the original peoples of North America and South America including Central America, and who maintains tribal affiliation or community attachment.
- Asian A person having origins in any of the original peoples of the Far East, Southeast Asia or Indian subcontinent including, for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands., Thailand and Vietnam.
- Black or African American A person having origins in any of the Black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.
- White A person having origins in any of the original peoples of Europe, North Africa, or Middle East.

Previous School Information

Has the student attended another BPS School? Yes No School: _____ Grade: ____ School Year: _____
Last School Attended Outside the Beatrice Public Schools Grade: ____ School: _____ School Year: _____
City: _____ State: _____ Principal _____ Counselor _____

Is your child presently under an expulsion order from any other school district? Yes No
Has the term (time period) of expulsion been completed Yes No If "no" state the reason for the expulsion and the term (time period) of the expulsion _____

Is your child presently under consideration for expulsion? Yes No
Is your child presently involved in the Juvenile Justice system? Yes No
Is your child a Ward of the State? Yes No

EL Information

1. What language did the student first learn to speak? _____
2. What language is spoken most often by the student? _____
3. What language is primarily used in the student's home regardless of the language spoken by the student? _____
4. The student speaks: No English Some English Another Language and English Equally Mostly or Only English
5. Is the student attending the school as a foreign exchange student? Yes No

FOR OFFICE USE ONLY: Forward to Student Programs Yes No

Special Services Information

Is your child receiving special education services? Yes No
Does your child have a current 504 plan? Yes No if yes, please indicate if related to: Academics Health
Was your child in any Gifted/Talented programs? Yes No if yes, please list _____
Does your child have any medical alerts? Yes No if yes, please explain on Student Health Information Form page 4.

Beatrice Public Schools
Student Parent Information
Page 2 of 5

Student's Name: _____

Teacher/Counselor: _____

Room: _____

Birth Date: _____

Student Lives With: Please check one box

Both Parents Mother Only Father Only Mother/Stepfather Father/Stepmother
Foster Parents Relatives _____ Other

Note: When a student does not reside with both parents, additional information must be on file so that the school can determine who is responsible for the student. If there are applicable legal documents, such as custody papers, a copy should be provided to the school. Additional paperwork (Student Enrollment- Appendix I and/or Power of Attorney) may be provided and required by the district.

PARENT/GUARDIAN INFORMATION SECTION

Please Fill In All Information for the Parent/Guardian Living with the Student

Name: _____ Relationship to Student: _____ Legal Guardian Yes No

Resident Address: _____

Unlisted Yes

Household Telephone: _____ No Work Telephone: _____ Cell Telephone: _____

Place of Employment: _____ Hours Worked: _____

E-mail Address: _____

Additional Information: _____

Name: _____ Relationship to Student: _____ Legal Guardian Yes No

Resident Address: _____

Unlisted Yes

Household Telephone: _____ No Work Telephone: _____ Cell Telephone: _____

Place of Employment: _____ Hours Worked: _____

E-mail Address: _____

Additional Information: _____

Please Fill In All Information for the Parent/Guardian Not Living with the Student

Name: _____ Relationship to Student: _____ Legal Guardian Yes No

Resident Address: _____

Unlisted Yes

Household Telephone: _____ No Work Telephone: _____ Cell Telephone: _____

Place of Employment: _____ Hours Worked: _____

E-mail Address: _____

Additional Information: _____

Name: _____ Relationship to Student: _____ Legal Guardian Yes No

Resident Address: _____

Unlisted Yes

Household Telephone: _____ No Work Telephone: _____ Cell Telephone: _____

Place of Employment: _____ Hours Worked: _____

E-mail Address: _____

Additional Information: _____

**Beatrice Public Schools
Student Emergency Information
Page 3 of 5**

Student's Name: _____

Teacher/Counselor _____
Room _____

EMERGENCY CONTACT INFORMATION SECTION – Please list in order to call if parents cannot be reached. Please include your Day Care Provider, Doctor and Dentist.

Name: _____ Relationship to Student: _____
Household Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Additional Information: _____

Name: _____ Relationship to Student: _____
Household Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Additional Information: _____

Name: _____ Relationship to Student: _____
Household Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Additional Information: _____

Day Care Provider: _____ Relationship to Student: _____
Phone Number: _____ Cell Telephone: _____

Additional Information: _____

Doctor: _____ Phone Number: _____

Dentist: _____ Phone Number: _____

SIBLING INFORMATION SECTION – Please list all members of this family who are under the age of 21.

Name: _____ Gender M/F: _____ Birth Date: _____ School Attending: _____

Name: _____ Gender M/F: _____ Birth Date: _____ School Attending: _____

Name: _____ Gender M/F: _____ Birth Date: _____ School Attending: _____

Name: _____ Gender M/F: _____ Birth Date: _____ School Attending: _____

FIELD TRIP INFORMATION SECTION – To be completed for Elementary Students Only

Throughout the school year, classroom teachers will have the opportunity to take their students on a variety of “trips”. These trips are designed to enhance the curriculum being presented in the classroom. Many of these trips will be taken in a school bus or van, but from time to time the students may walk to the destination should it be located close to the school building. Classroom teachers will notify parents of the trips through their classroom newsletter or a specific note. We ask that you sign below so that we may keep it on file in the school office.

I give permission _____ to attend field trips for the _____ school year. I understand that my child will be transported on a school bus, van or may walk if the destination is close to the school building.

To the best of my knowledge the information on pages 1-3 is accurate. By signing below, I state that I am the child's parent or legal guardian.

Date

Parent/Guardian Signature

**Beatrice Public Schools
Student Health Information
Page 4 of 5**

Student Name: _____ Student ID#: _____ Teacher/Counselor _____
Room _____

Medical Alerts (Asthma, Allergies, etc).

Medical Alert 1: _____

Medical Alert 2: _____

Medication Information

Is your child taking any medication regularly? Yes No

If yes, please list the medication(s): _____

Is your child allergic to any medication(s)? Yes No

If yes, please list the medication(s): _____

Indicate allergic reaction: _____

Student Medication Request Release Agreements are available at the school office. This form must be completed for any medication a student will need to take during school hours.

Immunization Information

*In order for your child to attend school, immunization documentation needs to be on file at the school by the first day of attendance. If immunization documentation is **NOT** complete, the student **MUST** see the school nurse or designee before enrollment can be completed.*

Doctor/Primary Care Provider

Doctor: _____

Telephone: _____ Extension: _____

Hospital: _____

Dentist _____

Telephone: _____ Extension: _____

Hospital: _____

If parents and family physician cannot be reached at the time of an emergency and if immediate treatment is urgent in the judgment of those in charge, do you authorize and direct the school authorities to send the child properly accompanied, to the hospital or doctor available?

Parent Signature: _____ Date: _____

**Beatrice Public Schools
Student Health Information
Page 5 of 5**

Student Name: _____ Student ID# _____

Teacher/Counselor _____
Room _____

Health Concerns Parents/Guardians are responsible for providing full details on any medical condition to the school nurse

Check and explain where appropriate	Medication(s)	Medication Given At Home		Medication Given At School	
		YES	NO	YES	NO
<input type="checkbox"/> Allergies					
<input type="checkbox"/> Asthma					
<input type="checkbox"/> Attention Deficit Disorder					
<input type="checkbox"/> Bowel/Bladder					
<input type="checkbox"/> Diabetes					
<input type="checkbox"/> Emotional/Behavioral					
<input type="checkbox"/> Fractures					
<input type="checkbox"/> Head Injury					
<input type="checkbox"/> Hearing					
<input type="checkbox"/> Headaches					
<input type="checkbox"/> Heart					
<input type="checkbox"/> Hyperactivity					
<input type="checkbox"/> Seizures or Fainting					
<input type="checkbox"/> Skin Conditions					
<input type="checkbox"/> Speech					
<input type="checkbox"/> Surgeries / Hospitalizations					
<input type="checkbox"/> Tuberculosis					
<input type="checkbox"/> Varicella (Chickenpox)					
<input type="checkbox"/> Vision					
<input type="checkbox"/> Other					

Does your child have a health problem?

Student has NO health concerns

- Please check all that apply
- Glasses Contacts Hearing Aids
- Prosthesis or Physical Aids (please list)
- Other _____

Information obtained on the Health History is solely used by the school nurse to ensure that sound decisions are made to meet the health needs of your student. Health information will only be shared with school staffs on a "needs to know basis" and parents/guardians will be included in this process. Health information will not be shared with any other outside health providers without the expressed written permission of the parent/guardian. If you have any questions or concerns please contact your student's school nurse.

Parent Signature: _____ Date: _____