ACSD
Addison Central School District

Student Information - Enrollment Form

(for newly enrolled students)

☐ Bridport (PK-6) ☐ Cornwall (PK-6) ☐ Mary Hogan (PK-6) ☐ Ripton (PK-6) ☐ Salisbury (PK-6)
☐ Shoreham (K-6) ☐ Weybridge (K-6) ☐ MUMS (7-8) ☐ MUHS (9-12) ☐ EEE Outreach

Legal Name: *(Last, First, Middle, Suffix)*		
Preferred Name:		
Date of Birth:	Gender: ☐M ☐F	Student Home Phone:
Anticipated start date:		Grade:
Student's physical home address:		
City:	State:	ZIP Code:
Mailing Address (if different):		
City:	State:	ZIP Code:
Town of Residence: *proof of residency required (see page 3)*	Any other last name the student has used:	
Race and Ethnicity questions are for reporting purposes only Race Info (check all that apply): ☐Black/African-American ☐American Indian/Native Alaskan ☐Asian ☐Native Hawaiian/Pacific Islander ☐White/Caucasian		
Is the student Hispanic? ☐Yes ☐No		
Current school (Name, City, State):	Date last attended:	
Has this student ever attended any school in our district? (including UPK) ☐Yes ☐No	If so, which school?	

Education Plan and Special Services

Did the student attend 10+ hours of preschool per week? ☐Yes ☐No	Are you experiencing housing issues? ☐Yes ☐No	
Does the student have current or previous educational plans? ☐IEP ☐504 ☐EST ☐None		
Is the student: ☐ school choice? ☐ homeschooled? ☐ tuitioned? ☐ foreign exchange? If so, country of origin: _____		
Is the student in DCF custody? ☐Yes ☐No	If in DCF custody, does the student have a parent/legal guardian living in the district? ☐Yes ☐No	Which town?
DCF Caseworker:	DCF Phone Number:	
Educational Surrogate (Name; Phone):	Guardian ad Litem (Name; Phone):	
Address:	Address:	

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Student's Name:_____ Birth Date:_____

Contact Information *(All parents and guardians with whom the student resides and with whom they do not)*	
Contact 1 Name:	**Contact 2 Name:**
Relationship to student:	Relationship to student:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Address:	Address:
Employer:	Employer:
Student lives with ☐Yes ☐No ☐Shared	Student lives with ☐Yes ☐No ☐Shared
Contact 3 Name:	**Contact 4 Name:**
Relationship to student:	Relationship to student:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Address:	Address:
Employer:	Employer:
Student lives with ☐Yes ☐No ☐Shared	Student lives with ☐Yes ☐No ☐Shared
Are there any Court Orders of which the school should be aware? ☐Yes ☐No *If yes, please attach a copy of the order.*	

Emergency Contacts *(other than parents)*			
Name:		Name:	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone:	
Work Phone:		Work Phone:	
Town of Residence:		Town of residence:	
Relationship to student:		Relationship to student:	

Siblings *(List all other children in the household who are under 18)*					
First Name:	Last name:	Grade:	School:	DOB:	

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Student Health Information - Enrollment Form

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Please note: Confidential information about your child's health may be shared only with other school staff that need to know to protect your child's safety. They are told to keep this health information private and not to share with anyone else. If there is health information you would like not to be shared, please contact the school nurse.

Student's Name:_____ Birth Date:_____ Age:_____ Entering Grade:_____

Medical History:	
Birth History: At how many weeks gestation was your child born? _____weeks gestation. What if any complications were there?	
Has your child ever been a **patient in a hospital** (other than a few days after birth)? ☐Yes ☐No *(If yes, explain why and when below.)*	
History of Hospitalization and/or Surgery:	**When**
(ex: bike accident - concussion)	*5 years old*

Medication History:		
Is your child taking any **prescription medicines** including an inhaler or breathing treatment? ☐Yes ☐No *(If yes, list the child's medicines below)*		
Name of medicine / reason	**Amount**	**How many pills or doses does your child take at what times?**
		_____morning _____noon _____evening _____bedtime
		_____morning _____noon _____evening _____bedtime
		_____morning _____noon _____evening _____bedtime
		_____morning _____noon _____evening _____bedtime
What **over-the-counter medicines** does your child take **regularly**? ☐ Vitamins ☐ Herbal medicine (please list): ☐ Other medicines like Tylenol, Advil? (please list): ☐ **None**, my child does not take any over-the-counter medicines regularly.		

Allergies:	**Yes**	**No**	**Please explain what your child is allergic to and what happens when your child has a reaction.**
Environmental Allergies *(ex: grass, pollen, dust)*			*(ex: dust / swollen eyes and runny nose)*
Food Allergies *(ex: peanuts, milk, wheat)*			
Insects or Animal Allergies *(ex: bees, wasps, cats)*			
Medicine or Vaccines			

Does your child have an Epi-Pen or Auvi-Q? ☐Yes ☐No
*(If yes, please provide your school with a current **Emergency Action Plan** from your primary care provider)*

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Student's Name:_____ Birth Date:_____

Medical Conditions/Injuries *(If yes, please circle or describe the appropriate condition and provide additional detail.)*			
	Yes	**No**	**Date / Additional Details** *(If yes, provide date(s))*
Chicken Pox			
Head Injury or Concussion			
Ear Infections *(ex: often has them, ear tubes)*			
Hearing *(ex: has trouble sometimes, wears hearing aid, implants)*			
Nose *(ex: sinus infection, nosebleeds)*			
Eye *(ex: blurry vision, wears glasses/contacts, lazy eye)*			
Mouth or Throat *(ex: strep throat, swallowing issues)*			
Toileting Issues *(ex: bedwetting, toilet training, soiling underwear)*			
Constipation/Bladder *(ex: pain when urinating, history of urinary tract infections)*			
Back *(ex: scoliosis, back pain)*			
Muscle and Bone *(ex: weak muscles, pain in joints, sprain or strain, broken bones)*			
Skin *(ex: acne, flaking skin, rashes, hives, eczema/psoriasis)*			
Neurological *(ex: history of seizures, frequent or severe headaches/migraines)*			
ADD/ADHD *(ex: trouble paying attention or sitting still)*			
Breathing *(ex: cough, asthma, pneumonia, bronchitis, frequent respiratory colds)*			*(If asthma, please provide the school a copy of the child's Asthma Action Plan)*
Heart *(ex: fast or irregular heartbeat, murmur, birth defect, history of heart disease, activity restrictions)*			
Feelings/Emotions *(ex: depression, anxiety, fears/phobias, traumatic life event)*			
Eating *(ex: anorexia, bulimia, malnourishment)*			
Sleeping *(ex: trouble sleeping)*			

Other: