Fill form out online, then print | Reset Form

ST. CLOUD AREA SCHOOLS STUDENT ENROLLMENT FORM

If you need assistance in filling out this form, please call 320-257-3811

Today's Date: 9/18/17 Grade entering: _____ School: _____ Language Immersion ☐ Yes ☐ No

STUDENT INFORMATION

Student's Legal
Last Name | First Name | Middle Name | Date of birth | Gender ☐ Male ☐ Female

Student's Address | Apt. # | Student's Home Phone (include area code)

City | State | Zip Code | County of Residence

Are you staying in shelter or other temporary housing? ☐ Yes ☐ No | Country of Birth

Are you a military family? ☐ Yes ☐ No ☐ Active Duty ☐ Reserve

Student's Ethnicity: (check one)
Dual reporting required by Federal Law 2008-2009 school year

☐ 1. American Indian/Alaskan native
☐ 2. Asian/Pacific Islander
☐ 3. Hispanic
☐ 4. Black (not Hispanic origin)
☐ 5. White (not Hispanic origin)

Student's Race:

1. Is the student Hispanic or Latino? ☐ Yes ☐ No

What is the student's race? (check all that apply)

☐ 2. American Indian or Alaskan Native
☐ 3. Asian
☐ 4. Black or African American
☐ 5. Native Hawaiian or Pacific Islander
☐ 6. White

Student's Previous School Experience:

DATE first enrolled in US school: _____

DATE first enrolled in MN school: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian's Last Name | First Name | Relationship to student | Home Phone

Address | Apt. # | City | Cell Phone

State/Zip Code | E-mail Address | Language Spoken | Work Phone | Ext

Parent/Guardian's Last Name | First Name | Relationship to student | Home Phone

Address | Apt. # | City | Cell Phone

State/Zip Code | E-mail Address | Language Spoken | Work Phone | Ext

Student lives with: (Check all that apply)

☐ Mother ☐ Father ☐ Mother & _____ ☐ Father & _____ ☐ Guardian ☐ Foster Parents ☐ Ward of the State ☐ Spouse ☐ Alone ☐ Other: _____

EDUCATION/SCHOOL HISTORY

School District where child received **Early Childhood Screening**: _____ **School District of Residency** _____

Does the student have any **special needs**? (i.e. special ed., health, etc.) ☐ YES ☐ NO If yes, please identify: _____

Has the student ever attended a public school in St. Cloud? ☐ YES ☐ NO If yes, what school(s)? _____

School most recently attended, if other than a St. Cloud Public School: **School Name:** _____

City: _____ Phone: _____ Date last attended: _____

FAMILY INFORMATION (please list other children who live in the same household)

Last name	First and Middle name	Birth date	Gender	School	Ethnicity (see below)	Race (see below)	Home Language	Birth Country

Ethnicity: (Select only one)

- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Hispanic
- ☐ Black (not Hispanic)
- ☐ White (not Hispanic)

Race: (Select all that apply)

- ☐ Hispanic or Latino
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

EMERGENCY CONTACT INFORMATION

Please provide names and telephone numbers of individuals that can be contacted locally for emergency purposes if parents can not be reached.

Emergency Contact #1: Name _____

Relation to student _____ Daytime Phone _____

Address _____ City, State, Zip Code _____

Emergency Contact #2: Name _____

Relation to student _____ Daytime Phone _____

Address _____ City, State, Zip Code _____

MEDICAL CONTACT INFORMATION

Physician/Medical Office: _____ Phone _____

Dentist: _____ Phone _____

Photo Release: Occasionally various media representatives (i.e., newspaper, TV, radio, and District 742 Media Services) will cover newsworthy school events and wish to use pictures of students. Often, pictures or video will be taken and students may be identified. If you, DO NOT want your child photographed in an identifiable manner, please sign here: _____

Migrant Work Information: Has either the parent/student moved to this school district within the last 3 years to find a job in agriculture, fishing, dairy or poultry work as a temporary or seasonal worker? ☐ Yes ☐ No

Parent/Legal Guardian Signature: _____ Relationship to Student: _____

FOR OFFICE USE ONLY:

School Accepting Registration _____ Student's starting date _____

Legal name and birthdate verified by ____ birth certificate ____ passport ____ other _____

742 ID number assigned _____ MARSS State ID number _____

Data entered into student system _____ Revised: 9/12/17

Please note: Information will be used for the administration and management of this student's educational program. You are encouraged but not legally required to complete all items on this form. Kindergarten: Any child is eligible for kindergarten who is or will be 5 years old on or before September 1st or any child who transfers into this system during the school year who has attended a regular kindergarten class in another school district. Birth Certificate: A legal birth certificate, passport, I-94 or other similar identification form must be brought to the school district at the time of registration if entering Kindergarten or registering for the first time in a MN school. Such certificates will be returned to you promptly. Immunization Certificate: Minnesota State Law (Statute 121A.15) requires all children at the time of initial entry to public school to submit a signed statement from a physician or public immunization clinic stating that the child has been immunized against Diphtheria, Tetanus, Pertussis, Mumps, Rubeola (hard, red) Measles, Rubella (German) Measles, Polio, Varicella and Hepatitis B. Exceptions in the law are provided for the child whose health would be endangered by such immunizations or one who is being reared as adherent of a religious denomination whose teachings are opposing such immunizations. This certificate must be on file in your child's school (in compliance with Minnesota State Law).

Minnesota Language Survey

Minnesota is home to speakers of more than 100 different languages. The ability to speak and understand multiple languages is valued. The information you provide will be used by the school district to see if your student is multilingual. In Minnesota, students who are multilingual may qualify for a Multilingual Seal upon further assessment. Additionally, the information you provide will determine if your student should take an English proficiency test. Based upon the results of the test, your student may be entitled to English language development instruction. Access to instruction is required by federal and state law. As a parent or guardian, you have the right to decline English Learner instruction at any time. Every enrolling student must be provided with the Minnesota Language Survey during enrollment. Information requested on this form is important to us to be able to serve your student. Your assistance in completing the Minnesota Language Survey is greatly appreciated.

Student Information	
Student's Full Name: (Last, First, Middle)	Birthdate or Student ID:

	Check the phrase that best describes your student:	Indicate the language(s) other than English in space provided:
1. My student first learned:	☐ language(s) other than English. ☐ English and language(2) other than English ☐ only English	
2. My student speaks:	☐ language(s) other than English. ☐ English and language(2) other than English ☐ only English	
3. My student understands:	☐ language(s) other than English. ☐ English and language(2) other than English ☐ only English	
4. My student has consistent interaction in:	☐ language(s) other than English. ☐ English and language(2) other than English ☐ only English	

Language use alone does not identify your student as an English learner. If a language other than English is indicated, your student will be screened for English language proficiency.

Parent/ Guardian Information	
Parent/Guardian Name (printed):	
Parent/Guardian Signature:	Date:

* All data on this form is private. It will only be shared with district staff who need the information to best serve your student and for legally required reporting about home language and service eligibility to the Minnesota Department of Education. At the district and at the Minnesota Department of Education, this information will not be shared with other individuals or entities, except if they are authorized by state or federal law to access the information. Compliance with this request for information is voluntary.

St. Cloud Area Schools Transportation Request and Change Form
(Including Daycare Requests)

- Please complete this form:
  - if your child is a new student who will become an active bus rider or
  - for changes regarding daycare use, home address or phone number
- Any changes to your child's pick-up or drop-off location requires: parent/guardian signature and requested started date for this action to take place.
- Each student is allowed one bus stop for the a.m. and one stop for the p.m. Parents are responsible for their own temporary arrangements.
  - please allow up to three (3) business days for transportation requests to be completed

REASON FOR REQUEST

☐ New student
☐ Daycare (new or change)
☐ Parent chooses to self-transport: ☐ a.m. ☐ p.m.
☐ Change of address/phone

STUDENT INFORMATION

Student's Name (Please print): _____ ID# _____
Parent/Guardian Name: _____
Home Address: _____
Home Phone: _____ Emergency phone: _____

SCHOOL/PROGRAM

School _____ Grade _____

Immersion Programs:
☐ Chinese Immersion (Madison)
☐ Spanish Immersion (Clearview)

PICK-UP/DROP-OFF INFORMATION

Pick up student by:
☐ home address ☐ daycare address

Drop off student by:
☐ home address ☐ daycare address

DAYCARE INFORMATION

Provider's name _____ Phone number _____
Address _____

Requested start date: _____ School Year _____

SIGNATURE

Parent/Guardian signature: _____ Date _____

RETURN TO: DISTRICT TRANSPORTATION, 737 OSSEO AVE. SO., ST. CLOUD, MN 56301 or EMAIL DSB@ISD742.ORG
PHONE: 253-9370 FAX: 320-529- 4341

OFFICE USE ONLY

Completed by: _____ Date _____

Revised: 8/7/17

St. Cloud Area Schools
Early Childhood Screening

Minnesota law requires Early Childhood Screening for all children entering Kindergarten in a public school.

STUDENT INFORMATION

Child's name _____ **DOB** _____

Parent's name(s) _____

Parent Address _____

_____ **Phone** _____

Email _____

SCREENING INFORMATION

Has your child gone through Early Childhood Screening?

☐ **NO** If no, please complete the following information:

☐ **YES** If yes, please complete the following information:

Where was your child screened?

☐ Colt's Academy/Roosevelt Education Center – District 742
☐ Special Education – Early Childhood Screening – District 742
☐ Head Start – St. Cloud
☐ Other Minnesota school district:
Name _____ City/State_____
☐ Other Head Start program:
Name _____ City/State _____

PARENT/GUARDIAN INFORMATION

I hereby grant permission to release Early Childhood Screening records for my child.

I understand that this record contains identifying data, ECS records, immunization records and other pertinent information concerning my child. (Parents may examine a copy of records upon request.)

_____ _____
(Parent/Guardian signature) (Date)

Please forward all Early Childhood Screening records to:

Early Childhood Education at Colt's Academy
124 1st Avenue Southeast
St. Joseph MN 56374
Phone: 320-253-5828
Fax: 320-529-4320

St. Cloud Area School District 742!
Prepare. Engage. Educate. Empower. Inspire.

ANNUAL STUDENT HEALTH INFORMATION
PLEASE PROVIDE A COMPLETE LIST OF STUDENT'S IMMUNIZATIONS UPON ENTRANCE TO KINDERGARTEN AND GRADE 7, AND STUDENTS NEW TO THE DISTRICT.

Student Name: **Birthdate:** **School Year:**

Gender: **School:** **Grade:** **Other ID:** **Home Room:**

HEALTH CARE

Primary Care Provider/Clinic Name _____

Health Care Specialists (neurology, behavioral, orthopedic, etc.)/Clinic Name _____

Has your child had a physical examination within the past year: **Y** or **N** Date ____/____/____

1. Check any current health condition listed below about which the school should be aware:

- ☐ ADHD ☐ Anxiety ☐ Depression
- ☐ Allergies:
  - Food _____ Symptoms _____
  - Bee Sting _____ Symptoms _____
  - Environmental _____ Symptoms _____
  - Latex _____ Symptoms _____
  - Medication _____ Symptoms _____
- My Child has an EpiPen **Y** or **N**
- Is this a medical emergency? **Y** or **N**
- ☐ Asthma: Inhaler **Y** or **N** Type _____
- ☐ Autism/Aspergers
- ☐ History of Chicken pox: **Y** or **N**
  If yes, Month/Year ____/____
- ☐ Diabetes: Insulin Pump _____ Pen _____
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Hearing: Aids _____ Tubes _____
- ☐ Vision: Glasses _____ Contacts _____
- ☐ Scoliosis
- ☐ Other Health Conditions (kidney, heart, lung)

_____

2. Does your child have any disabilities, physical limitations or developmental delays: Y or N If YES, please explain:

_____

_____

3. List any serious illness or injury that occurred in the past year: _____

_____

4.

MEDICATIONS	DOSAGE	TIMES PER DAY	REASON FOR MED	TAKEN AT HOME	TAKEN AT SCHOOL

5. Has your child had any immunizations this past year? Include mm/dd/yy

Tdap ____/____/____ **DPT** ____/____/____ **Polio** ____/____/____ **MMR** ____/____/____ **Td booster** ____/____/____

Varicella (chicken pox) ____/____/____ **Menactra** (Meningitis) ____/____/____

Hep B ____/____/____ ____/____/____ ____/____/____ **Hep A** ____/____/____ ____/____/____ ____/____/____

Gardisil (HPV) ____/____/____ ____/____/____ ____/____/____

Please remember to inform your child's bus driver if your child has a condition that may lead to an emergency situation on the bus. NO medications, prescription or over the counter, are given to a student unless prescribed by the child's physician and provided by the parent. Annual written consent to dispense medication is required from the parent and the physician. Medication to be dispensed must be brought to school by the parent in a pharmacy labeled bottle. The above information may be shared with staff.

Parent/Guardian Signature _____ **Date** _____

Partners for Student Success

St. Cloud Area School District 742 for you

SAUK RAPIDS-RICE Public Schools

United Way of Central Minnesota

Early Childhood Background Information

Thank you for taking the time to fill out this information. We will utilize the information gathered to best support your child's' educational needs.

* 1. Please enter the following information.

Student's First Name

Student's Last Name

* 2. Student's Date of Birth

	MM	DD	YYYY
Date	/	/	

* 3. Please select the district in which your child will be attending Kindergarten.

- Sartell-St. Stephen School District 748
- Sauk Rapids-Rice School District 47
- St. Cloud Area School District 742

4. Did your child participate in any licensed early childhood experiences outside the home *(Licensed In-Home Family Child Care, Center Based Child Care, Early Childhood Family Education Classes, public or private/faith-based preschool, Head Start Center Based program or Early Head Start/Head Start Home Based program)* prior to attending Kindergarten ?

- Yes
- No

Partner for Student Success

St. Cloud Area School District 742 for you

SAUK RAPIDS-RICE Public Schools

United Way of Central Minnesota

Licensed Early Childhood Experiences

Please continue to answer only the questions that apply to your child. If your answer is no, you do not need to respond to that question.

5. If your child attended a Licensed In-Home Family Child Care since birth for more than six months, select all ages that apply.

- [ ] Birth to 1
- [ ] Age 1
- [ ] Age 2
- [ ] Age 3
- [ ] Age 4
- [ ] Age 5

What was the name of the most recent primary licensed in-home family child care provider?

6. If your child attended Center-Based Child Care since birth for more than six months, select all ages that apply.

- [ ] Birth to 1
- [ ] Age 1
- [ ] Age 2
- [ ] Age 3
- [ ] Age 4
- [ ] Age 5

What was the name of the most recent primary center-based child care program that your child attended?

7. If your child attended Early Childhood Family Education (ECFE) classes since birth for more than six months, select all ages that apply.

- [ ] Birth to 1
- [ ] Age 1
- [ ] Age 2
- [ ] Age 3
- [ ] Age 4
- [ ] Age 5

8. If your child attended Early Childhood Education (ECFE) classes, where did he/she attend? Select all that apply.

- [ ] Sartell-St. Stephen School District ISD 748
- [ ] Sauk Rapids-Rice School District ISD 47
- [ ] St. Cloud Area School District ISD 742
- [ ] Other (please specify)

9. If your child attended preschool through a public school district, select all ages that apply.

- [ ] Age 3
- [ ] Age 4
- [ ] Age 5

10. If your child attended preschool classes in a public school district, where did he/she attend? Select all that apply.

- [ ] Sartell-St. Stephen School District ISD 748
- [ ] Sauk Rapids-Rice School District ISD 47
- [ ] St. Cloud Area School District ISD 742
- [ ] Other (please specify)

11. If your child attended preschool through a private/faith-based preschool, select all ages that apply.

- [ ] Age 2
- [ ] Age 3
- [ ] Age 4
- [ ] Age 5

What was the name of the private/faith-based preschool(s) your child attended?

12. If your child attended a Head Start Center-Based program, select all ages that apply.

- [ ] Age 3
- [ ] Age 4
- [ ] Age 5

13. If your child attended an Early Head Start/Head Start Home-Based program, select all ages that apply.

- [ ] Birth to 1
- [ ] Age 1
- [ ] Age 2
- [ ] Age 3
- [ ] Age 4
- [ ] Age 5

United Way Imagination Library

14. Did your child participate in the United Way Imagination Library Book Program?

- Yes
- No

15. At what ages did your child receive books from the United Way Imagination Library Book Program? Select all ages that apply.

- [ ] Birth to 1
- [ ] Age 1
- [ ] Age 2
- [ ] Age 3
- [ ] Age 4
- [ ] Age 5

Thank You!

Thank you for taking the time to complete this survey. We will utilize the data from this survey to best support your child's educational needs. If you have questions, please contact the Early Childhood Coordinator or Director in your District:

Sartell-St. Stephen: Sarah Funk, 320-656-3763

Sauk Rapids-Rice: Megan Rogholt, 320-258-1101

St Cloud Area: Julie Midas, 320-253-5828