

ST. CLOUD AREA SCHOOLS STUDENT ENROLLMENT FORM

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

Today's Date: _____ Grade entering: _____ School: _____

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 a shelter of other temporary housing? ____ Yes ____ No
 Are you a military family? ____ Yes ____ No ____ Active Duty ____ Reserve
 Country of Birth _____

Student's Ethnicity: (check one) Dual reporting required by Federal Law 2008-2009 school year <input type="checkbox"/> 1. American Indian/Alaskan native <input type="checkbox"/> 2. Asian/Pacific Islander <input type="checkbox"/> 3. Hispanic <input type="checkbox"/> 4. Black (not Hispanic origin) <input type="checkbox"/> 5. White (not Hispanic origin)	Student's Race: 1. Is the student Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No What is the student's race? (check all that apply) <input type="checkbox"/> 2. American Indian or Alaskan Native <input type="checkbox"/> 3. Asian <input type="checkbox"/> 4. Black or African American <input type="checkbox"/> 5. Native Hawaiian or Pacific Islander <input type="checkbox"/> 6. White	Student's Language: Language student first learned to speak: _____ Language student normally uses at home: _____ Language parent most frequently uses to speak with child: _____
---	---	--

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

EDUCATION/SCHOOL HISTORY

School District where child received Early Childhood Screening: _____ School District of Residency _____
 Date first enrolled in US school: _____ First enrolled in MN school: _____

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

<p>Ethnicity: (Select only one)</p> <p>1. American Indian/Alaskan Native 4. Black (not Hispanic) 2. Asian/Pacific Islander 5. White (not Hispanic) 3. Hispanic</p>	<p>Race: (Select all that apply)</p> <p>1. Hispanic or Latino 4. Black or African American 2. American Indian or Alaskan Native 5. Native Hawaiian or Pacific Islander 3. Asian 6. White</p>
---	--

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: 4/7/16

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, Rubella (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).

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 Parent chooses to self-transport: a.m. p.m.
 Daycare (new or change) 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 PH: 253-9370/ FAX: 320-529- 4341

OFFICE USE ONLY

Completed by: _____ Date _____

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



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

Date

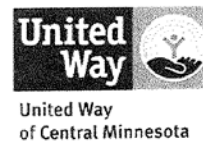
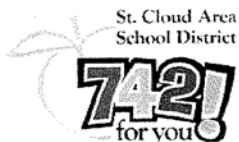
	MM		DD		YYYY
	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>

* 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



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