BILLINGS PUBLIC SCHOOLS
PK-12 ENROLLMENT FORM

OFFICE USE ONLY	Student State ID:	Birth Certificate: ❑ Yes ❑ No	Immunizations Received: ❑ Yes ❑ No	School Entry Date: School Name:

I. Student Information

1.(LEGAL NAME ONLY) Last Name	First	Middle	Suffix (Jr, II, III)

2. Other name(s) used previously (AKA):	**3.** Nickname:

4. Grade:	**5.** Birth Date: / /	**6.** Birth Place (city, state)	**7.** Gender ❑ Male ❑ Female	**8.** Is student a US Citizen? ❑ Yes ❑ No

9. Previously enrolled in Billings Schools if yes: Date:______________ Grade: _____ School:	❑ Yes ❑ No	**11.** Is student Hispanic or Latino? ❑ Yes ❑ No	**12.** Race (Select one or more):**indicate % of each race** ❑ ______% White ❑ ______% Native Hawaiian or Other Pacific Islander ❑ ______% Black or African American ❑ ______% Asian ❑ ______% American Indian or Alaska Native Tribal Affiliation: ______________________ (Please attach 506 form with enrollment form)
10. Previously enrolled in a Montana School if yes: Date:_____________ Grade: ______ School:	❑ Yes ❑ No	**13.** Primary Phone ( )	
14. Language(s) Spoken at Home		**15.** Student's Primary Language	

16. Home Address	City	State	Zip Code
17. Mailing Address (if different than home address)	City	State	Zip Code

II. Parent and Emergency Contact Information

18. PARENT/GUARDIAN

❑ Lives with student
❑ Student's Legal Guardian
❑ Mailing List
❑ Receive BPS news by email

Last Name		First Name	
Relation to Student	Email Address	Place of Employment	
Home Address (if different than Box 16)	City	State	Zip Code
Mailing Address (if different than home address)	City	State	Zip Code
Primary Phone ( )	Work Phone ( )	Cell Phone #1 ( )	Cell Phone # 2 ( )

19. PARENT/GUARDIAN OTHER

❑ Lives with student
❑ Student's Legal Guardian
❑ Mailing List
❑ Receive BPS news by email

Last Name		First Name	
Relation to Student	Email Address	Place of Employment	
Home Address (if different than Box 16)	City	State	Zip Code
Mailing Address (if different than home address)	City	State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone #1 ( )	Cell Phone # 2 ( )

20. LOCAL EMERGENCY CONTACT (Other than Parent/Guardian)

Last Name		First Name	
Relation to Student	Home Phone ( )	Work Phone ( )	Cell Phone ( )
Home Address	City	State	Zip Code

21. ADDITIONAL CONTACT

Last Name		First Name	
Relation to Student	Home Phone ( )	Work Phone ( )	Cell Phone ( )
Home Address	City	State	Zip Code

Please attach separate sheet if more contact information is needed

OFFICE ONLY Student Name: ______ Grade: ______ Teacher/Counselor: ______ Student ID: ______

III. Siblings

22. Complete this section only if applicable. Include only siblings who are currently in Grade PK-12 in Billings Public Schools

Sibling	Grade	School Name
Sibling #1 full name:	Grade:	School Name:
Sibling #2 full name:	Grade:	School Name:
Sibling #3 full name:	Grade:	School Name:
Sibling #4 full name:	Grade:	School Name:

IV. Previous Schools

	Name of School	City	State	Grades
23. Last Elementary School Attended				
24. Last Middle School Attended				
25. Last High School Attended				
26. Any additional schools attended in the past year				

OFFICE USE ONLY	Records Requested: / /	Records Received: / /

V. QUESTIONS FOR PARENTS

27. Has student ever received service from or been involved in: (check all that apply):

❑ Special Education ❑ Title 1 ❑ Reading Tutor ❑ Section 504 ❑ Speech Therapy

❑ English 2nd Language ❑ Behavior Management ❑ Counseling ❑ Gifted Program

❑ Other:

28. Have you been engaged in migrant work in the last three years? ❑ Yes ❑ No

29. Has student immigrated to the United States ❑ Yes* ❑ No
*if yes: date first enrolled in US School:

30. Has this student ever been under long term suspension or been suspended from school? ❑ Yes ❑ No

31. Legal Bindings: Please list any legal binding information, including restraining orders, custody agreements that are pertinent to this student and his/her safety: (copy of the legal documentation is required).

32. Is there any other information that would help us better serve your student?

All information provided in sections I to V are complete and accurate to the best of my knowledge.

✘ ______________________________ ______________________
Parent/Guardian signature (required) *Date*

OFFICE ONLY Student Name: ________ Grade: ________ Teacher/Counselor: ________ Student ID: ________

Health and Medical Information

❑ **Allergies to**: ❑Bee Sting ❑Food ❑ Environment ❑Latex ❑Medication ❑ Other

Name of Medication(s): ______

❑ ***needs medication at School** ❑ takes medication at home

Describe reaction and intervention: ______

List other allergies:

❑ **Asthma:**
Name of medication(s) ______
❑ ***needs medication at School** ❑ takes medication at home ❑ carries inhaler on person ❑ inhaler in school office

❑ **Attention Deficit Disorder:**
Name of Medication(s) ______
❑ ***needs medication at School** ❑ takes medication at home ❑ diagnosed but no medication

❑ **Diabetes:** ❑ ***Insulin dependent/ needs school program set up** ❑***Self manages snacks, diet, testing, coverage**

❑ **Headaches:**
Name of medication(s)

❑ **Seizures:**
Name of medication(s) ______
❑ ***needs medication at School** ❑ takes medication at home ❑ history of seizure but not currently on medication

❑ **Other Medications:** ❑ ***needs medication at School** ❑ takes medication at home Diagnosis: ______

Name of medication(s)

❑ **Hearing Concerns:**
(Please explain)

❑ **Vision Concerns:**
(Please explain)

❑ **Physical Restrictions:**

❑ ***Uses mobility aide (wheelchair, walker, crutches, etc.)**

❑ ***Restricted because of** ______

❑ Must avoid this/these activities ______
(Doctor's letter is required for some P.E. adaptations)

❑ **Other:** Describe health history (operations, serious accidents, and serious illness)

______
______
______
______

Diseases/Conditions: If known, please indicate the year of the disease/condition when applicable:

❑ Chicken Pox ❑ Measles(Rubella) ❑ Mumps ❑ Rubella (3 day) ❑ Scarlet Fever ❑ Sinusitis
❑ Eczema ❑ Whooping Cough ❑ Heart Disease ❑ Rheumatic Fever ❑ Kidney/Bladder Disorder ❑ Congenital Condition

❑ Other(please describe):

Hospital Sign Off: In case of an emergency, I authorize medical/dental care:
Please indicate hospital of choice: ❑ Billings Clinic ❑ St. Vincent's ❑ Either

Doctor's name:	**Dentist's name:**

***NOTE:** All items will require notification of the school nurse. If medication is needed, the parent must complete a medication authorization form before the first dose of medication can be given at school. This health concern information may be shared with school personnel as necessary to benefit the health and safety of this student and others. Please keep school staff informed as to changes to the information so the student's records can be updated as needed.

______ ______
Parent/Guardian signature (required) *Date*

OFFICE ONLY Student Name: ______ Grade: ______ Teacher/Counselor: ______ Student ID: ______