APW CENTRAL SCHOOL DISTRICT
Student Enrollment Verification Form
(To be completed by a Parent or Guardian)
Complete all information and sign where appropriate.
Please provide the following with completed form:
Student's Birth Certificate, Shot Record, Proof of Residency, Custody Paperwork (if applicable)

Student Last Name: _____ Gender: **M** / **F** **Gr:**

First Name: _____ Middle: _____

Date of Birth: _____ Student Home Phone: _____

Student Address: _____

_____

☐ Please check if your student receives special education services?

Mailing Address: _____

_____

☐ IEP ☐504

Parent/Guardian Information:

The Schooltool Parent Portal provides parents and guardians access to assignments, grades and attendance information. To receive access, you must provide a valid email address and receive mail regarding the child.

Contact Call Order _____

#1 Parent/Guardian:

Name: _____ Custody: Yes/ No Student lives with: Yes / No

Relationship: _____ Receives Mailings: Yes / No

Receives Email: Yes / No

Address: _____ Mailing Address: _____

_____ _____

Phone Call Order

Employer: _____ Home Phone: _____ 1 2 3

Email: _____ Cell Phone: _____ 1 2 3

Work Phone: _____ 1 2 3

Please provide me with access to the Schooltool Parent Portal for my child? Yes / No

_____ **#2 Parent/Guardian**:

Name: _____ Custody: Yes/ No Student lives with: Yes / No

Relationship: _____ Receives Mailings: Yes / No

Receives Email: Yes / No

Address: _____ Mailing Address: _____

_____ _____

Phone Call Order

Employer: _____ Home Phone: _____ 1 2 3

Email: _____ Cell Phone: _____ 1 2 3

Work Phone: _____ 1 2 3

Please provide me with access to the Schooltool Parent Portal for my child? Yes / No

Is your child Hispanic, Latino, or of Spanish origin? Yes / No

Check all racial groups that apply to your child:

☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Other Pacific Islander ☐Black ☐White

Has the student ever attended APW School District? Yes / No

Please list up to four adults to contact if you cannot be reached in case of an emergency:

1. Name: _____ Telephone: _____
   Relationship: _____ Allowed to pick up student? Yes / No Cell Phone: _____

2. Name: _____ Telephone: _____
   Relationship: _____ Allowed to pick up student? Yes / No Cell Phone: _____

3. Name: _____ Telephone: _____
   Relationship: _____ Allowed to pick up student? Yes / No Cell Phone: _____

4. Name: _____ Telephone: _____
   Relationship: _____ Allowed to pick up student? Yes / No Cell Phone: _____

Do you have any children in your household that have not reached school age? Yes / No

Name: _____ Date of Birth: _____ Gender: M / F
(last, first)

Name: _____ Date of Birth: _____ Gender: M / F
(last, first)

Parental Opt-Out/In:

_____ **I do not** want my child's name, photograph, artwork, or film footage released by APW Central School District

_____ **I would like** to receive 48 hours prior notification of pesticide application that are scheduled to occur in your school.

_____ (Gr 9-12 only) **I do not want** my child's name/directory information shared with any organization for purposes of recruitment.

_____

Printed Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian **Date**

Student Confidential Health Form

Student Name: _____**Date of Birth**_____ Grade: _____

Address: _____ Mailing (if different): _____

_____

Emergency Contact:

Parent/Guardian _____ Parent/Guardian _____

Phone: H _____,C_____,W_____ Phone: H _____,C _____,W_____

Alternate Contacts:

1._____Daytime Phone: _____

2._____Daytime Phone: _____

Please check below any conditions affecting your child which may affect his/her welfare in school.

- ☐ Drug Allergy
- ☐ Food Allergy
- ☐ Insect Allergy
- ☐ Environmental Allergy
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Asthma
- ☐ Arthritis
- ☐ Scarlet Fever
- ☐ Seizure Disorders
- ☐ Heart Condition
- ☐ Concussion
- ☐ Kidney Disease
- ☐ Vision Problems or Corrective Lenses
- ☐ Recent Injuries
- ☐ Recent Surgeries
- ☐ Hearing Problems
- ☐ History of concussion

If yes, how many? _____

List and explain, any items checked above and any illnesses, injuries, or health problems the child has had in the past year or is currently being treated for:

List the medications with dosages your child takes on a regular basis, include prescription and over the counter medications:

	Name of Drug	Dose and Frequency	Reason
1.			
2.			
3.			

My child wears: ☐ Glasses ☐ Contacts ☐ Hearing Aid(s) ☐ Orthodontic Braces

Other Brace: ☐ Arm ☐ Leg ☐ Back

Name of Health Care Provider: _____ Phone _____

Name of Dentist: _____ Phone _____

Permission for emergency medical treatment in case of injury or illness and parent/guardian is not available:

1. In an emergency, the information on this form may be given to emergency medical personnel. ☐ Yes ☐ No
2. I give permission for medical personnel to treat my child. ☐ Yes ☐ No
3. If my child must be hospitalized, my hospital preference is: _____
4. I give permission for my child to receive MD prescribed medication: ☐ Yes ☐ No

Parent/ Guardian Signature: _____ **Date:** _____

Print Name of Parent/ Guardian: _____