



## New Student Enrollment

Please bring the following documents to the K-12 School Office prior to the first day of school:

- FCSD #2 Enrollment Form (Two-Sided)

Students must turn FIVE years of age on - or - before August 1 of current school year to attend Kindergarten

- CERTIFIED BIRTH CERTIFICATE (we will make a copy):  
To acquire a copy, please request online at [www.vitalchek.com](http://www.vitalchek.com)

- Copy of current immunization record can be obtained:  
Call your child's medical provider -or- contact  
public health at 307-856-6979 or 307-332-1073

- Health Information Form (Two-sided)  
This will ensure your child's best care when at school

JoEllen McCabe  
Dubois K-12 Administrative Assistant  
Phone: 455-5524  
[jmccabe@fremont2.org](mailto:jmccabe@fremont2.org)

# FREMONT COUNTY SCHOOL DISTRICT #2

## Dubois K-12 School


700 North 1st St. Dubois, WY 82513 Phone (307) 455-5524 Fax (307) 455-2654

### Enrollment Form

**STUDENT DETAILS** - Pursuant to §W.S. 21-2-203, the school district is required to collect data for the Wyoming State Student Registration System.

#### STUDENT PERSONAL INFORMATION

Student's Legal Name: (as written on birth certificate)		Preferred name if different than legal name:	
Date of Birth:	Birthplace:	Age:	Grade Entering:
Social Security Number:    - - - - -		Gender: Male	Female
<b>ETHNICITY/RACE ORIGIN</b>			

Ethnicity	Race/Origin (choose all that apply)	
(Choose only one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> No, not Hispanic/Latino	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American. <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	

#### FAMILY INFORMATION

Parent/Legal Guardian Name(s):			
Physical Address:		Telephone Number:	
Mailing Address:	City	State	Zip Code
Father's Name:	Work Place:	Cell Number:	
email address:	Do you have legal custody?	Yes	No
Mother's Name:	Work Place:	Cell Number:	
email address:	Do you have legal custody?	Yes	No
Step-Father's Name:	Work Place:	Cell Number:	
email address:	Do you have legal custody?	Yes	No
Step-Mother's Name:	Work Place:	Cell Number:	
email address:	Do you have legal custody?	Yes	No

Please list siblings (name & age) :

**Student lives with (check one)**

<input type="checkbox"/> Both Mother & Father	<input type="checkbox"/> Shared Custody (split between parents)
<input type="checkbox"/> Mother ONLY    - or -	<input type="checkbox"/> Mother & Stepfather
<input type="checkbox"/> Father ONLY    - or -	<input type="checkbox"/> Father & Stepmother
<input type="checkbox"/> Other: (please specify): _____	<input type="checkbox"/> Court-appointed Guardian (attach court order)

Who has legal custody rights:     Father     Mother     Father/stepmother     Mother/Stepfather

**If parents are separated or divorced or child lives with guardian, please provide a copy of legal documentation.**

Non-Custodial Parent's name and phone number:  
Mailing Address:

#### Medical / Emergency Contact Information

**PLEASE LIST CONTACTS OTHER THAN PARENT/GUARDIAN:**

Emergency Contact #1 _____	Telephone Number: _____
Relationship to child: _____	Cell Phone Number: _____
Emergency Contact #2 _____	Telephone Number: _____
Relationship to child: _____	Cell Phone Number: _____

**Other person(s) authorized to represent student & their relationship to student:**

Name:	Relationship to student:	Phone #
Name:	Relationship to student:	Phone #
Name:	Relationship to student:	Phone #

**Home Language and Miscellaneous Information**

Do you have a certificate of eligibility for the Federal Migrant Program? Yes or No

Is your child currently on MEDICAID? Yes No

Was your student born in the U.S.A.? Yes No If no, in which country? \_\_\_\_\_ Date entered the U.S.? \_\_\_\_\_

Has your student attended a U.S. school for any 3 years during his/her lifetime? Yes No If yes, start date in US school: \_\_\_\_\_

First language spoken by student? \_\_\_\_\_ Language used most often at home: \_\_\_\_\_

Current language(s) spoken and understood by the student: \_\_\_\_\_

Is the student in Foster Care? Yes No (Only circle Yes if the State retains legal custody of the student)

Is one, or both of the student's parents or guardians on Active Duty, in the National Guard, or in the Reserve components of the United States military services? Yes No

**Previous School Information**

Most Recent School Attended: \_\_\_\_\_ City / State: \_\_\_\_\_

Has this student ever repeated or been asked to repeat a grade? \_\_\_Yes \_\_\_No Grade Repeated: \_\_\_\_\_

Any previous record of expulsion or out of school suspension? \_\_\_Yes \_\_\_No

Has your child participated in Special Education anytime during their school years? \_\_\_yes \_\_\_no

If yes, does your child have an IEP (Individualized Education Program) now? \_\_\_ yes \_\_\_ no

Please circle all areas in which your child has received special services:

Reading Writing Math Behavior Social Skills Study Skills Speech/Language Therapy Occupational/Physical Therapy

Other Services: *circle all that apply*

504 Plan ESL/ELL (Bilingual/English as a second language instruction) Title I Services Home School Private School

**To assure that your child is provided an appropriate education, enrollment may require a waiting period of up to 5 business days to determine residence, confirm guardianship, and review previous school records.**

**Transporation Information**

Will your child require school bus transportation? \_\_\_yes \_\_\_no

*Students should be at their bus stop 5 minutes before the scheduled time*

**DUBOIS K-12 SCHOOL WILL ASSUME NO LIABILITY FOR DAMAGE TO STUDENT VEHICLES OR FOR ANY LOSS WHILE THESE VEHICLES ARE OPERATED OR PARKED ON THE CAMPUS. PLEASE KEEP VEHICLES LOCKED AT ALL TIMES.**

# Request for Records



To: **Dubois K-12 School**

P.O. Box 188

Dubois, WY 82513

Phone: (307) 455-5524 / Fax: (307) 455-2654

or e-mail to: [jmccabe@fremont2.org](mailto:jmccabe@fremont2.org) (preferred method)

K-12 Principal: Mr. Taq Romsa

Date of request: \_\_\_\_\_ Records received: \_\_\_\_\_

Former School: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ FAX: \_\_\_\_\_

School's Email address: \_\_\_\_\_

*It is requested that a copy of the school records for:*

Student's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

*These records are to be released to F.C.S.D. #2. Please send all pertinent information including:*

- Academic Transcripts
- Achievement and other standardized test results
- Attendance and discipline reports
- Health and immunization records, sports physical information
- Psychological, speech and hearing reports
- Title I
- Special education records including: active IEP and current Diagnostic Summary:
  - Please e-mail to [ssplichal@fremont2.org](mailto:ssplichal@fremont2.org) or fax to (307) 455-2654.

**NOTE: FEDERAL LAW 99.31 STATES NO PARENT SIGNATURE ERQUIRED FOR EDUCATIONAL RECORDS  
SENT TO ANOTHER EDUCATIONAL AGENCY**

**Fremont County School District #2 School Health Information**

Student Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Parent/Guardian Name (s): \_\_\_\_\_ Home Phone \_\_\_\_\_

Medical Provider: \_\_\_\_\_ Clinic Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother: Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Father: Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**EMERGENCY CONTACTS (other than parents and must list at least one)**

1. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

**MEDICATION:** List all prescribed medication (s) that your child is currently taking and the diagnosis:

\*Medications that are to be given at school require a completed "Request for Administration of Medication Form"

**Tell us more about your child's health:**

**ALLERGIES:**

Does your child have any diagnosed allergies: Yes \_\_\_\_\_ No \_\_\_\_\_ Please list allergies and reactions:

Does your child require an epi-pen for these allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

Last occurrence of anaphylaxis \_\_\_\_\_ Symptoms of anaphylactic reaction \_\_\_\_\_

Does your child have asthma? Yes \_\_\_\_\_ No \_\_\_\_\_ Does your child use an inhaler? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child need to carry an inhaler with them at all times during the school day? Yes \_\_\_\_\_ No \_\_\_\_\_

Will your child be storing an inhaler in the nurse's office? Yes \_\_\_\_\_ No \_\_\_\_\_

Seizures? Yes \_\_\_\_\_ No \_\_\_\_\_ Cause of Seizures: \_\_\_\_\_ Date of last seizure: \_\_\_\_\_

Frequent headaches or migraines? Yes \_\_\_\_\_ No \_\_\_\_\_ Best treatment when they occur? \_\_\_\_\_

Diabetes? Yes \_\_\_\_\_ No \_\_\_\_\_ Management- Pump/Multi-dose Injections

Hearing loss? Yes \_\_\_\_\_ No \_\_\_\_\_ Hearing Aids? Yes \_\_\_\_\_ No \_\_\_\_\_

Speech difficulty? Yes \_\_\_\_\_ No \_\_\_\_\_

Glasses or Contacts? Yes \_\_\_\_\_ No \_\_\_\_\_ Diagnosed color blindness? Yes \_\_\_\_\_ No \_\_\_\_\_

**MEDICATIONS PROVIDED AT SCHOOL**

The following medications are provided at school. **Please check all that you will allow your child to receive at school:**

**Acetaminophen (Tylenol):** Yes \_\_\_\_\_ No \_\_\_\_\_

**Ibuprofen (Motrin/Advil):** Yes \_\_\_\_\_ No \_\_\_\_\_

**Cough Drop/Throat Lozenge:** Yes \_\_\_\_\_ No \_\_\_\_\_

**BENADRYL (For allergic reaction/rash):** Yes \_\_\_\_\_ No \_\_\_\_\_

**Topical Medicated Ointments such as Bacitracin and Hydrocortisone 1%:** Yes \_\_\_\_\_ No \_\_\_\_\_

I give permission for the school nurse or trained designee to dispense the medication listed above to my child if needed throughout the school day should I be unable to come and dispense.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE COMPLETE AND SIGN BOTH SIDES**

Students Name \_\_\_\_\_ Grade \_\_\_\_\_

**IMMUNIZATION INFORMATION**

Wyoming State Law requires your child to be properly immunized as designated by the State Health Officer. Your child will be conditionally enrolled for **30 calendar days**. If requirements are not met by the end of 30 days, your child will be excluded from school. Please provide the school nurse with a current immunization record when a new immunization is administered.

**A current immunization record must be on file with the school nurse.**

**HEALTH SCREENINGS**

Health screenings are an opportunity to gather important health information early. Some results require your child to receive a follow-up examination by your healthcare provider.

The school nurse screens selected grades for vision, hearing, and color blindness. Upon completion, results are mailed home.

**MEDICATION POLICY**

If your child requires medication during school hours, the following procedure is to be followed:

1. A **"Request for Administration of Medication"** form **MUST** be completed and signed by a parent/legal guardian and medical provider. This form will be reviewed by the school nurse prior to medication being administered.

2. The prescribed medication will be brought to the school nurse with the required paperwork.

3. Students taking over-the-counter medication from home will also adhere to the above policy.

4. **Prescription medication brought to the school nurse in anything other than the original prescription bottle will not be administered to the student.**

5. All medication will be stored and locked in the nurse's office. **\*EXCEPTION:** Inhalers may be carried by the student if the form has been signed on the Request for Administration of Medication Form by the parent/legal guardian and prescribing medical provider, and is on file in the school nurse's office.

Medications that can be given outside of school hours should be. Antibiotics that are four times a day are an exception.

I have read and understand the information above regarding Immunizations, Health Screenings, and the FCSD#2 medication policy.

**\*School Nurse WYIR Access Agreement:** To ensure the Wyoming Department of Health is aligning with HIPPA laws, Wyoming School Nurses must obtain a parent/guardian agreement before accessing student immunization records within the Wyoming Immunization Registry (WYIR). Do you consent to access of your child's immunization records? **Yes** \_\_\_\_ **No** \_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_