



## Little Rams Enrollment

- FCSD #2 Enrollment Form (Two-Sided)
- Copy of CERTIFIED BIRTH CERTIFICATE:  
This can be requested online at [www.vitalchek.com](http://www.vitalchek.com)
- Copy of current immunization record  
Can be obtained:  
Call your child's medical provider  
Or 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

# 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:
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Date of Birth:	Birthplace:	Age:	Grade Entering:	Today's Date:	
Social Security Number:      - - - - -		Gender:    Male      Female			

#### ETHNICITY/RACE ORIGIN

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	<div style="font-family: cursive; color: blue; font-size: 1.2em;">                     Home of the  <b>DUBOIS</b>  <b>RAMS</b> </div> 

#### 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.**

### Transportation 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.**

**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 FCSD #2 access to your child's immunization records? **Yes** \_\_\_\_ **No** \_\_\_\_

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



# School Nurse

Anna Hinkle LPN  
District Nurse and Food Service Director  
455-5511  
[ahinkle@fremont2.org](mailto:ahinkle@fremont2.org)

Office hours- 7:30a-3:45p

Please, never hesitate to call or email me with any health-related questions. That's why I'm here. I believe in strong communication to ensure the best experience for your child.

## Meals at Preschool:

When your child enrolls in the preschool program we are currently able to provide breakfast, lunch, and an afternoon snack under a Federal Program called the Child and Adult Care Food Program-CACFP. Under this program, we are given funding per meal and afternoon snack based on the household income of the enrolled child. You will be given an application to fill out prior to school starting in August. It is imperative, the application is filled out and returned on the first day of preschool. I will mail these to you. Please make sure your mailing address is current on the enrollment form you complete. If you choose not to fill out the application, please notify me and there is an alternate form to sign. Your child eats for free, we just get a much lower reimbursement for the meal and snack.

**\*\*Please call and notify Little Rams when your student will not be eating meals for the scheduled day. We do our best to eliminate waste in our Food Service Department. We cook the meals at our K-12 school and send them to the Little Rams building. It's important to get the accurate count for the day in a timely manner.**

If your child has a food allergy, please contact me prior to August 1. There is an additional form that needs to be completed by you and your medical provider, signed by both you and the medical provider, and returned to me. You also have the option of packing your child's lunch if you prefer.

Whew, that's a lot of information! Once the paperwork is in, the rest is a breeze 😊.

Let me swap hats now!

### Immunizations:

Children attending a public or private school, preschool, Head Start, or child-caring facility must be vaccinated against the following diseases based on their age: ([Wyoming Department of Health](#))

\*\*If you have any questions or need to schedule an appointment for immunizations, please call Fremont Public Health at 307-856-6979 or 307-332-1073.

Please provide a copy of the most recent immunization record for your child at enrollment. I will review the records provided and notify you if your child is missing immunizations to start preschool in August. Please plan to have your child up to date by August to prevent any delays in starting school.

### 3-year-old students:

- DTap-4 doses
- Hib-3 or 4 doses
- Pneumococcal-4 doses
- Rotavirus-3 doses
- Hepatitis B-3 doses
- Polio (IPV)-3 doses
- MMR-1 dose
- Varicella-1 dose

### 4-6-year-old students:

- DTap-5 doses
- Polio (IPV)-4 doses
- MMR-2 doses
- Varicella-2 doses

Once the 4-6-year-old immunizations are complete, your child is ready for Kindergarten.

When your child turns 12 they will be ready to get a Tdap booster.

Again, please contact me with any questions or concerns regarding your child's health, immunizations, or the food program.

Anna Hinkle  
District Nurse and Food Service Director