*PLEASE PRINT* **MINOCQUA J1 SCHOOL ENROLLMENT FORM** **Phone: (715)356-5206 Fax (715)358-2649**

**OFFICE USE ONLY** Birth Certificate Verified _____ Birth City:_____ State:_____County:_____

START DATE _____ TEACHER _____ Student Number _____

## STUDENT INFORMATION

**REVIEW OF YOUR CHILD'S BIRTH CERTIFICATE, documentation of compliance with Wisconsin immunization laws, and documentation of residence within the MHLT School District are required for registration and enrollment. Please return completed enrollment form and required documentation to MHLT School, 7450 Titus Drive, Minocqua, WI 54548.**

_____ _____ _____ _____

Last Name First Name Middle Initial Student's Previous Name(s)

Birthdate _____ Gender _____ Grade _____ Home Phone # _____

**Primary Residence:**

Home Address _____ City_____ State_____ Zip_____

Mailing Address _____ City_____ State_____ Zip _____

## PREVIOUS SCHOOL INFORMATION

Number of schools attended in the last 2 years? _____

Name of School_____Address_____

Name of School_____Address_____

## PARENT/GUARDIAN CONTACT INFORMATION:

**PLEASE PROVIDE *LEGAL DOCUMENTATION* REGARDING SPECIAL CUSTODY ARRANGEMENTS.**

_____ _____ Home Phone _____

**Mother Last Name** **Mother First Name**

E-mail _____ Cell Phone _____

**DOES STUDENT LIVE WITH THIS PARENT? YES☐ NO☐ IS PARENT AUTHORIZED TO PICK UP? YES☐ NO☐**

**SHOULD THIS PARENT RECEIVE STUDENT MAILINGS? YES☐ NO ☐**

Home Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

Mother's Employer_____ Work Phone _____

_____ _____ Home Phone _____

**Father Last Name** **Father First Name**

E-mail _____ Cell Phone _____

**DOES STUDENT LIVE WITH THIS PARENT? YES☐ NO☐ IS PARENT AUTHORIZED TO PICK UP? YES☐ NO☐**

**SHOULD THIS PARENT RECEIVE STUDENT MAILINGS? YES☐ NO ☐**

Home Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

Father's Employer_____ Work Phone _____

## OTHER LIVE-IN ADULT INFORMATION

**DOES THIS ADULT HAVE PERMISSION TO PICK UP? YES☐ NO☐**

Name _____ Relationship_____

Cell Phone_____ Work Phone_____

## EMERGENCY CONTACTS (Other than parents/live-in adults)

1. _____ Relationship_____Phone_____
2. _____ Relationship_____Phone_____
3. _____ Relationship_____Phone_____

## SCHOOL CENSUS

Please list all persons **less than twenty (20) years of age** residing in the home, who have no other legal residence.

| NAME | GRADE | GENDER | AGE | BIRTHDATE | SCHOOL: Pre/Elem/H.S. |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## LANGUAGE-USE PATTERN and CULTURAL BACKGROUND

Race and Ethnicity: Please answer BOTH questions 1. and 2.

1. Is this student Hispanic or Latino? (Choose only one)☐No, not Hispanic or Latino ☐Yes, Hispanic or Latino

2. Is this student: (choose one or more; you must select at least one)

| | | | |
|---|---|---|---|
| American Indian | ☐ | Native Hawaiian or Other Pacific Islander | ☐ |
| Asian | ☐ | White | ☐ |
| African American | ☐ | | |

1. Number of years child has lived in the United States? _____
2. Number of years student has been in school? _____ In what country?_____
3. Languages spoken in the home: English?_____ Other(s)? _____
4. Which language did your child first learn to speak? _____
5. Which language(s) do you primarily speak ***to*** your child at home? _____
6. Which language(s) does your child use most frequently at home to communicate with parents/siblings?

_____

**Unique Educational Needs: Please check any and all that apply.**

### SPECIAL EDUCATION/IEP SERVICES

| | |
|---|---|
| **Student has current IEP** | ☐ |
| Speech and Language | ☐ |
| Emotional Disabilities | ☐ |
| Cognitive Disabilities | ☐ |
| Other Health Impairment | ☐ |
| Visually Impaired | ☐ |
| Hearing Impaired | ☐ |

### EDUCATIONAL SERVICES

| | | |
|---|---|---|
| Reading Intervention Services | ☐ | _____ |
| Written Language Services | ☐ | _____ |
| Math Intervention Services | ☐ | _____ |
| Behavioral Intervention Svcs. | ☐ | _____ |
| Gifted and Talented Services | ☐ | _____ |

Area: _____

Things we need to know to best serve your child: _____

_____

Physician's Name_____ Phone No. _____

### MEDICAL/HEALTH CARE NEEDS

**Please check any and all that apply.**

| | | | | |
|---|---|---|---|---|
| Attention Deficit Disorder | ☐ | Epilepsy/Seizures | ☐ | |
| Asthma | ☐ | Physical Disabilities | ☐ | _____ |
| Uses Inhaler | ☐ | 504 Plan on File | ☐ | |
| Diabetes | ☐ | at previous school | | |
| Medication Needs | ☐ | Other | ☐ | _____ |
| Allergies | ☐ | | | |

**Do school authorities have parental consent to administer tylenol or ibuprofen? Yes☐ No☐**

**(Dosage will be age and weight appropriate according to manufacturers directions.)**

**Do school authorities have parental consent to seek medical treatment in case of emergencies? Yes☐ No☐**

**Parent Signature** _____ **Date**_____