

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 CENSUSPlease 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	<input type="checkbox"/>	Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>
Asian	<input type="checkbox"/>	White	<input type="checkbox"/>
African American	<input type="checkbox"/>		

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	<input type="checkbox"/>
Emotional Disabilities	<input type="checkbox"/>
Cognitive Disabilities	<input type="checkbox"/>
Other Health Impairment	<input type="checkbox"/>
Visually Impaired	<input type="checkbox"/>
Hearing Impaired	<input type="checkbox"/>

EDUCATIONAL SERVICES

Reading Intervention Services	<input type="checkbox"/>	_____
Written Language Services	<input type="checkbox"/>	_____
Math Intervention Services	<input type="checkbox"/>	_____
Behavioral Intervention Svcs.	<input type="checkbox"/>	_____
Gifted and Talented Services	<input type="checkbox"/>	_____

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	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	Physical Disabilities	<input type="checkbox"/>	_____
Uses Inhaler	<input type="checkbox"/>	504 Plan on File	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	at previous school	<input type="checkbox"/>	_____
Medication Needs	<input type="checkbox"/>	Other	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>			

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 _____