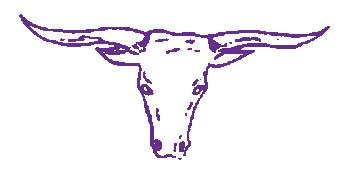
**FORSYTH PUBLIC SCHOOL**

“The Dogies”

School District No. 4 and Forsyth High School District

PO Box 319

Forsyth, MT 59327

406-346-2796

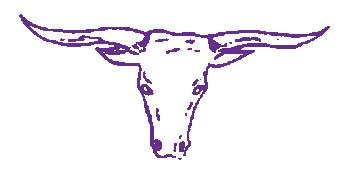
Dear Parents:

Welcome to the Forsyth School District. We look forward to having your child(ren) as students!

The necessary forms needed to register your child(ren) into the Forsyth School District are found in this section. This registration packet is a fillable online document. Please make sure that you thoroughly complete, review and print the entire packet. One packet is needed for each child entering the district. The student(s) will not be able to register if the packet is incomplete.

After you complete the registration packet, you can come in to the High School/Jr. High School office to register. Remember to bring all the required documents from the list on the next page as well as your completed registration packet.

Students will be registered for classes or officially enrolled after all information is complete. We look forward to meeting you and your student.



OFFICE USE ONLY: PS ID#\_\_\_\_\_\_\_\_

Building: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_

Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Transcript Faxed: \_\_\_\_\_\_\_\_ Imm. Faxed: \_\_\_

Release Mailed/Faxed: \_\_\_\_\_

Out of District Student: \_\_\_\_\_

Student’s Full LEGAL Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name as it appears on his/her birth certificate

**Welcome to Forsyth Public Schools!**

**Please have the following information before coming in to register. If you have questions you may contact the High School/Jr. High School Office at 406-356-2796 ext. 5140 or the Elementary School Office at 406.346-2796 ext. 5120.**

* Completed Registration Packet
* Student’s Certified Birth Certificate
* Student’s complete Immunization Record
* Personal Picture Identification of adult registering student (driver's license)

If the student is not living with both natural or adoptive parents, a certified copy of the most current Court Order Establishing Custody or Guardianship is required.

* Final Judgment-Court stamped
* Child-Care Agreement – Notarized (Call office for details)

**The following information is required for proper class placement and scheduling.**

* Copy of Last Grade Report (K-8) or Unofficial Transcript (9-12)

**Please answer each question.**

Has your child ever been provided special education services: \_\_\_\_\_Yes \_\_\_\_\_No

Does your child currently have an IEP for special education services: \_\_\_\_\_Yes \_\_\_\_\_No

Does your child currently have a 504-Plan? \_\_\_\_\_Yes \_\_\_\_\_No

**If you answered yes to any of the questions above, please bring copies of any supporting documents. These items include copies of your child’s most recent IEP, 504 Plan, etc.**

**As the parent/legal guardian, you have a continuing duty to immediately inform the school of any change of residence or custody. I have read and understand the above enrollment procedures. I agree to notify the Forsyth Public Schools of any changes which may occur as outlined above. Initial here: \_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***OFFICE USE ONLY*** | Date:  School:  Bus Route: | Birth Certificate:  ❑ Yes  ❑ No | Immunizations Received:  ❑ Yes  ❑ No | PS ID:  State ID: |



***FORSYTH PUBLIC SCHOOLS K-12 ENROLLMENT FORM***

***“Home of the Dogies”***

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **STUDENT INFORMATION** | | | | | | | | | | |
| (LEGAL NAME ONLY) Last Name First Middle Suffix (Jr, II, III) | | | | | | | | | | |
| Other name(s) used previously (AKA): | | | | Student Email: | | | | | | |
| Grade: | Birth Date: | Birthplace (city, state) | | | Gender  ❑ Male ❑ Female | | | Is student a US Citizen?  ❑ Yes ❑ No | | |
| Previously enrolled in Forsyth Schools:  if yes: Date: Grade: ❑ Yes ❑ No | | | Is student Hispanic or Latino?  ❑ Yes ❑ No | | | | Race (Check all that apply):  ❑ White  ❑ Native Hawaiian or Other Pacific Islander  ❑ Black or African American  ❑ Asian  ❑ American Indian or Alaska Native  Tribal Affiliation:  (Please attach 506 form with enrollment form) | | | |
| SchoolPreviously enrolled in:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Student Cell Phone: | | | |
| Home Address (Physical address) | | | | | | City | | | State | Zip Code |
| Mailing Address (if different than home address) | | | | | | City | | | State | Zip Code |

**STUDENT PHOTO AT STATE LEVEL:** The local school district will upload my student's photo to the state information system to help the Department of Justice find missing children.

**STUDENT PHOTO: \_\_\_\_\_\_\_OPT-IN\_\_\_\_\_\_OPT-OUT**

**SCHOOL MESSAGING: \_\_\_\_\_\_\_OPT-IN\_\_\_\_\_\_OPT-OUT**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **RESIDENTIAL PARENT/GUARDIAN (Complete only if LIVING with student)** | | | | | | |
|  | **Parent/Guardian 1** | | |
| Last Name | | | | | First Name | | | |
| Relation to Student | | Email Address | | | Employer | | | |
| Home Address (if different than above) | | | | | City | State | Zip Code | |
| Mailing Address (if different than home address) | | | | | City | State | Zip Code | |
| Home Phone | | | Work Phone | | Cell Phone | | | |
|  | **Parent/Guardian 2** | | |
| Last Name | | | | | First Name | | | |
| Relation to Student | | Email Address | | | Employer | | | |
| Home Address (if different than above) | | | | | City | State | Zip Code | |
| Mailing Address (if different than home address) | | | | | City | State | Zip Code | |
| Home Phone | | | Work Phone | | Cell Phone | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **NON-RESIDENTIAL Parent/Guardian Information** | | | | | | | |
|  | **Parent/Guardian 1** | | |
| Last Name | | | | | First Name | | | |
| Relation to Student | | Email Address | | | Employer | | | |
| Home Address (if different than above) | | | | | City | State | Zip Code | |
| Mailing Address (if different than home address) | | | | | City | State | Zip Code | |
| Home Phone | | | Work Phone | | Cell Phone | | | Copy of Correspondence?  Yes No |
|  | **Parent/Guardian 2** | | |
| Last Name | | | | | First Name | | | |
| Relation to Student | | Email Address | | | Employer | | | |
| Home Address (if different than above) | | | | | City | State | Zip Code | |
| Mailing Address (if different than home address) | | | | | City | State | Zip Code | |
| Home Phone | | | Work Phone | | Cell Phone | | | Copy of Correspondence?  Yes No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **EMERGENCY CONTACT (Other than Parent/Guardian Contacts already listed)** | | | |
|  | **Contact 1** | |
| Last Name | | | | First Name |
| Relation to Student | | | | |
| Home Phone | | Work Phone | | Cell Phone |
|  | **Contact 2** | |
| Last Name | | | | First Name |
| Relation to Student | | | | |
| Home Phone | | Work Phone | | Cell Phone |

|  |  |
| --- | --- |
| **QUESTIONS FOR PARENTS** | |
| Has student ever received service from or been involved in: (check all that apply):  ❑ Special Education ❑ Title 1 ❑ Reading Tutor ❑ Section 504 ❑ Speech Therapy | |
| ❑ Current IEP ❑ Behavior Management ❑Counseling ❑ Gifted Program | |
| ❑ Other: | |
| Have you been engaged in migrant work in the last ❑ Yes three years? ❑ No | Has student immigrated to the United States ❑ Yes\*  \*if yes: date first enrolled in US School: ❑ No |
| Has this student ever been under long term suspension/ ❑ Yes  expulsion or been suspended/expelled from school? ❑ No | **Is there any other information that would help us better serve your student?** |
| **Legal Bindings:** Please list any legal binding information, including restraining orders, custody agreements that are pertinent to this student and his/her safety: (copy of the legal documentation is required). |
| **Dependent of Active Duty Military Member:** Is this student the dependent of an active duty military member? If so:  Name of Military Member: Relationship:  ❑ The US Military (Army, Navy, Air Force, Marines, or Coast Guard)  ❑ Active Duty National Guard  ❑ Active Duty Reserve Force of the US Military  ❑ Transitioning out of Active Duty to National Guard or Reserve |  |

**All information provided above is complete and accurate to the best of my knowledge.**

*Parent/Guardian signature (required) Date*

|  |  |  |
| --- | --- | --- |
| **Health and Medical Information** | | |
| ❑ | **Allergies to**: ❑Bee Sting ❑Food ❑Environment ❑Latex ❑Medication ❑ Other  Name of Medication(s):  ❑ **\***needs medication at School ❑ takes medication at home  Describe reaction and intervention: List other allergies: | |
| ❑ | **Asthma:**  Name of medication(s)  ❑ **\***needs medication at School ❑ takes medication at home ❑ carries inhaler on person ❑ inhaler in school office | |
| ❑ | **Attention Deficit Disorder:**  Name of Medication(s)  ❑ **\***needs medication at School ❑ takes medication at home ❑ diagnosed but no medication | |
| ❑ | **Diabetes:** ❑ **\***Insulin dependent/ needs school program set up ❑**\***Self manages snacks, diet, testing, coverage | |
| ❑ | **Headaches:**  Name of medication(s) | |
| ❑ | **Seizures:**  Name of medication(s)  ❑ **\***needs medication at School ❑ takes medication at home ❑ history of seizure but not currently on medication | |
| ❑ | **Other Medications:** ❑ **\***needs medication at School ❑ takes medication at home Diagnosis:  Name of medication(s) | |
| ❑ | **Hearing Concerns:**  (Please explain) | |
| ❑ | **Vision Concerns:**  (Please explain) | |
| ❑ | **Physical Restrictions:**  ❑ **\***Uses mobility aide (wheelchair, walker, crutches, etc.)  ❑ **\***Restricted because of  ❑ Must avoid this/these activities (Doctor’s letter is required for some P.E. adaptations) | |
| ❑ | **Other:** Describe health history (operations, serious accidents, and serious illness) | |
| **Diseases/Conditions:** If known, please indicate the year of the disease/condition when applicable:  ❑ Chicken Pox ❑ Measles(Rubella) ❑ Mumps ❑ Rubella (3 day) ❑ Scarlet Fever ❑ Sinusitis  ❑ Eczema ❑ Whooping Cough ❑ Heart Disease ❑ Rheumatic Fever ❑ Kidney/Bladder Disorder ❑ Congenital Condition  ❑ Other(please describe): | | |
| **Medical Sign Off: In case of an emergency, I authorize medical/dental care:**  Please indicate hospital of choice: | | |
| **Doctor’s name:** | | **Dentist’s name:** |

**\*NOTE:** All items will require notification at the school office. If medication is needed, the parent must complete a medication authorization form before the first dose of medication can be given at school. This health concern information may be shared with school personnel as necessary to benefit the health and safety of this student and others. Please keep school staff informed as to changes to the information so the student’s records can be updated as needed.

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Parent/Guardian signature (required) Date*

**Disclosure of Information**

Disclosure of immunization information by schools is covered by the Family Educational Rights and Privacy Act (FERPA). (45 CFR 164.501)

**Permission Statement**

Immunization information on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Student’s Name)

will be shared with the local public health department (*Rosebud County Public*

*Health Department)* and/or entered into the electronic data system, *imMTrax.* This

information will be shared with healthcare providers to help prevent both over- and

under-immunization and to develop one consolidated vaccine record for the child.

The intent of an electronic immunization registry is to provide a complete and

permanent immunization record for your child.

I give my permission for my child’s vaccine information:

**\_\_\_\_** To be shared with the Rosebud County Public Health Department.

\_\_\_\_ To be entered into the statewide database, *imMTrax.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Student’s Full Legal Name Please Print) (Date of Birth)**

**(Parent/Guardian Name Printed) (Signature of Parent/Guardian) (Date)**

**(Mailing Address ) (Phone Number)**