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Stowstone School District # 69
Registration Information

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Home Phone: _____

Preferred Name: _____ Grade: _____

Mailing Address: _____ City: _____ ST: _____ ZIP: _____

Physical Street Address: _____

Date of Birth: _____ Gender: _____ Current Age: _____

Place of Birth: _____ State: _____ Birth Certificate? Y N

Ethnicity: _____ I-American Indian C-Caucasian B-African American P-Pacific Islander A-Asian O-Other H-Hispanic

Primary Language Spoken in Home: _____

Number of Brothers: _____ Ages: _____ Number of Sisters: _____ Ages: _____

Father: _____ Place of Employment: _____

Mailing Address, City, State, Zip (if different than student): _____

Home Phone: _____ Day Phone: _____ Has Custody? Y N

Mother: _____ Place of Employment: _____

Mailing Address, City, State, Zip (if different than student): _____

Home Phone: _____ Day Phone: _____ Has Custody? Y N

Other Live-in Adult: _____ Place of Employment: _____

Home Phone: _____ Day Phone: _____ Relationship: _____

Has Custody? Y N Parent/Guardian E-Mail Address: _____

Please number the following in order of desired contact: ___Mother ___Father ___Adult (1) ___Adult(2) ___Adult (3)

Please list three (3) adult contacts, in order of desired contact, to be called if parent/guardian cannot be reached:

Adult (1): _____ Relationship: _____ Day Phone: _____

Adult (2): _____ Relationship: _____ Day Phone: _____

Adult (3): _____ Relationship: _____ Day Phone: _____

Physician Name: _____ Physician Phone: _____

Does this student qualify for Special Ed? Y N Has your student ever qualified for Title I? Y N

Does this student take medication for any disorder? _____ If medication is necessary during school hours for the well being of this student, the child's physician must give the school a prescription and sign a school medical authorization form and the parent/guardian must sign a school medical authorization form.

Legal Alert

Is anyone legally barred from contacting this student? Y N Court Documentation & physical description must be provided to the school office.

Who? _____ Relationship to student: _____

Today's Date: _____ Parent/Guardian Signature: _____



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CARRYING KNIVES, GUNS OR OTHER WEAPONS

Dear Student and Parent:

Please read the following paragraphs, sign your names to indicate that you have read the contents and return this page to school.

With this notice, you are being made aware that there are federal, state and school laws prohibiting students from carrying knives, guns and other deadly or dangerous weapons while at school, on a school bus or at a school-sponsored activity.

A violator may be sentenced to a jail term or fined, or both, and shall be expelled from school for the violation.

School district employees may search students, their belongings, lockers and vehicles if a student is reasonably suspected of violating these laws.

School District #69 has a zero tolerance policy for weapons which provides for expulsion of students who are in possession of knives, guns or other items which threaten other students.

Please talk with your student(s) so that they are aware of the severe consequences of carrying a knife or other weapon to school or a school-related activity.

I have read and/or discussed the notice concerning the penalties for carrying knives, guns and other weapons.

Student Signature _____

Parent Signature _____

Date _____

PLEASE RETURN THIS FORM TO SCHOOL PROMPTLY. THANKS!



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**YELLOWSTONE SCHOOLS
DISTRICT #69
P.O. BOX 460
WEST YELLOWSTONE, MT 59758
(406)646-7617
(406)646-7232 FAX**

The Family Educational Rights and Privacy Act of 1974, as amended in 1976, allows school records to be forwarded without written consent to schools in which a student seeks or intends to enroll. (Federal Register, June 17, 1976; P. 24674.)

Please send us the cumulative record, including past and present academic, attendance, health and medical records, counseling files, standardized tests results, special education files and any other pertinent information for the following student(s):

Name of Student: _____

Date of Birth: _____ Present Grade Level: _____

Name of Student: _____

Date of Birth: _____ Present Grade Level: _____

Thank you,

Rick Armstrong, Counselor

Previous School:

Name of School: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Parent Signature: _____ Date: _____



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Form and Medical Release

Birth Date: _____ Grade _____

Home Phone: _____ Cell Phone: _____

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Parent/Guardian: _____

Business Address: _____ Business Phone: _____

Please number the following in order of desired contact: ___Mother ___Father ___Adult (1) ___ Adult(2) ___Adult (3) Please list three (3) adult contacts, in order of desired contact, to be called if parent/guardian cannot be reached:

Adult (1): _____ Relationship: _____ Day Phone: _____

Adult (2): _____ Relationship: _____ Day Phone: _____

Adult (3): _____ Relationship: _____ Day Phone: _____

Physician Name: _____ Physician Phone: _____

Does this student take medication for any disorder? _____ If medication is necessary during school hours for the well being of this student, the child's physician must give the school a prescription and sign a school medical authorization form and the parent/guardian must sign a school medical authorization form.

Complete the following information about the child:

Special Disability (if any): _____

Any special medical or dietary information necessary for management in an emergency situation (allergies, medications, special conditions): _____

Any additional information or special needs of the child: _____

Medical Release

Written consent is given for (Please check those items for which you give consent):

_____ Emergency Medical Care

_____ Administration of prescription as indicated on prescription label

_____ Administration of non-prescription medications: Please list all that

may be administered and the dosage. (Antacids i.e.: Tums, Maalox, etc.) We ONLY provide non-aspirin products (i.e. Acetaminophen)

I give my consent for _____ to be provided care in the event of an emergency. I understand this form will be used only in the event I cannot be reached to give consent.

Parent Signature

Date

PLEASE FILL OUT THE BACK SIDE OF FORM



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school-sponsored event becomes ill or injured and we are unable to
on for emergency medical treatment. Time is a critical factor.
treatment in case of an emergency.

I, _____, give my consent for _____
(Parent Name) (Student Name)

to be provided medical care in the event of an emergency. I understand that this form will only be used in the event that the parent cannot be reached to give consent.

Parent Signature Date

Other Emergency Information:

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Home Physical Address: _____

Relative or other person to be called if I cannot be reached:

Printed Name Phone

Any known medical or medication problems: _____
