FREMONT COUNTY SCHOOL DISTRICT NO. 2

Every Day Counts: Educate, Engage, Empower

Registration Requirements

The following information is required prior to the start of school:

- **FCSD #2 Enrollment Form**
- **Request for Records** if student records are to be transferred.
- **Completed Student Health Information Form** (this is 2 pages)
- **Home Language Survey**
- **A Certified Birth Certificate** that will be copied at school. If you do not have one you may order a copy online at www.vitalchek.com
- **Social Security Card**. Please submit card with registration information for us to copy.
- **Copy of immunization Record**

Immunizations

Wyoming State Law (W.S. 21-4-309) requires your child to be properly immunized against vaccine preventable disease as designated by the State Health Officer. **Your child may be conditionally enrolled for thirty (30) calendar days (not school days)**, after which time he/she will be excluded from school. Religious and Medical exemptions must be processed with the Wyoming Department of Health.

Requirements for all incoming Students:

- **DTAP 4-5 Doses** (At least one dose must be given on or after child's 4th birthday)
- **HIB Completed Valid 3 or 4 doses**. Depends on brand of vaccine received.
- **POLIO 4 Doses**
- **MMR 2 Doses**
- **HEP B 3 Doses**
- **Pneumococcal (PCV-13) 4 Doses**
- **Varicella Vaccine 2 Doses** or healthcare provider verified form stating child had the virus.
- **Tdap Booster at age 11 or 12**
- **Meningococcal ACWY at age 11 or 12 and booster at age 16 (Effective August 2020)**

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:***

Date of Birth: **Birthplace:** **Age:** **Grade Entering:** **Today's Date:**

Social Security Number: _ _ _ - _ _ -_ _ _ _ **Gender:** Male Female

ETHNICITY/RACE ORIGIN

PART A: *(Choose only one)*
- ☐ Hispanic/Latino
- ☐ No, not Hispanic/Latino

PART B: Race *(choose all that apply)*
- ____ American Indian or Alaska Native
- ____ Asian
- ____ Black or African American.
- ____ Native Hawaiian or Other Pacific Islander
- ____ White

PART C: Ethnicity *(Choose only one)*
- ___ American Indian or Alaska Native
- ___ Asian
- ___ Black or African American
- ___ Hispanic
- ___ Native Hawaiian or other Pacific Islander
- ___ White (not hispanic)
- ___ Two or more races

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)

- ☐ Both Mother & Father
- ☐ Mother ONLY - or -
- ☐ Father ONLY - or -
- ☐ Other: (please specify):_____
- ☐ Shared Custody (split between parents)
- ☐ Mother & Stepfather
- ☐ Father & Stepmother
- ☐ 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:

Flip over for further enrollment information

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 #

Miscellaneous Information

Is the student in Foster Care? Yes No

Is one, or both of the student's parents or guardians on Active Duty, in the National Guard, or in the Reserve componenets of the United States military services? Yes No

Previous School Information

Most Recent School Attended: **City / State:**

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 education 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.

Transporation 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 NO. 2

Every Day Counts: Educate, Engage, Empower

Home Language Survey:

As prescribed by Title VI of the Civil Rights Act of 1964, a Home Language Survey needs to be used to identify students at the time of enrollment in our school district.

Date _____ School _____ Grade: _____

Student Name: _____ Age: _____

Parent/Guardian Name: _____

Address _____

Home Phone _____ Work Phone _____

- Student Information:
  - Date of Birth: _____ (Month/day/year)
  - Was your student born in the U.S.? YES_____ NO _____
    - If yes, in which state? _____
    - If no, in which country? _____
    - If no, date student entered the U.S.? _____
- Student's U.S. Education:
  - Has your student attended a U.S. school for any 3 years during his/her lifetime? Yes __ No__
  - If yes, what date did your student start at a U.S. school? _____
  - If yes, please provide school name(s), state and dates attended:
    - School _____ State _____ Dates attended _____
    - School _____ State _____ Dates attended _____
    - School _____ State _____ Dates attended _____

1. Which language did your child first learn to speak? _____
2. What language does your child most often use at home? _____
3. What language do you most often use to speak to your child? _____

_____ _____

Parent/Guardian Signature Date

Rev. 11-19-14

Fremont County School District #2 School Health Information

Student Name _____ Male _____ Female _____ Grade _____

Date of Birth _____ Age _____ Parent/Guardian Name (s): _____ Home Phone _____

Physician Name: _____ 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 Information: List all prescribed medication (s) that your child is currently taking:

_____

_____

*Medications that are to be given at school requires a completed **"Request for Administration of Medication Form".** Information on back.

Does your child have any of the following medical problems:

ALLERGIES:

Does your child have any *serious allergies* (medication, food, insect bites, other) Yes _____ No _____

Please list allergies and type of reaction:

_____

_____

Does your child require and *epi-pen* for these allergies? Yes _____ No _____

Last occurrence of anaphylaxis _____ **Symptoms of anaphylactic reaction** _____

ASTHMA:

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 nurses office? Yes _____ No _____

*Medications that are to be given at school requires a completed **"Request for Administration of Medication Form".**

OTHER MEDICAL ISSUES:

Seizures? Yes _____ No _____ **Date of last seizure:** _____

Frequent headaches or migraines? Yes _____ No _____ **Best treatment when they occur?** _____

Hearing loss? Yes _____ No _____ **Hearing Aids?** Yes _____ No _____ **Diabetes?** Yes _____ No _____

Speech difficulty? Yes _____ No _____

Vision problems? 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, Triple Antibiotic Ointment, Hydrocortisone 1% Yes _____ No _____

I give permission for the school nurse or designee to dispense the above named medication 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.

Current immunization record must be on file with the school nurse.

HEALTH SCREENINGS

Health screenings are an opportunity to gather important health information early. Please remember these are **only screenings**. Some results may include the need for your child to receive a follow-up examination by your healthcare provider.

Please remember you may be asked to follow-up with your healthcare provider, based on the screening findings.

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 by a parent/legal guardian, and returned to the school nurse **prior** to dispensing any medication. Medication will not be dispensed otherwise.
2. Students taking medication prescribed by a physician **MUST** bring the medication in the original container, provided by the pharmacy, to the school secretary, principal or school nurse. A doctor's order must accompany the medication. A copy of the prescription is acceptable.
3. Students taking an over the counter medication that has been sent from home, must bring the medication in the manufacturers original container.
4. **Do not send loose medications in small baggies or plastic containers.**
5. Students must take all medication in the presence of designated school personnel. EXCEPTION: SEE #6 below*
6. All medication will be stored and locked in the nurses office. *EXCEPTION: Inhalers may be carried by the student if the exception form has been signed on the Request for Administration of Medication Form by the parent/legal guardian and is on file in the school nurse's office.

Please note It should be understood that it will be the student's responsibility to come to the office to get medication and that the school is under no obligation to contact the child should he/she forget.

We feel in fairness to those giving the medication and for the safety of your child, these policies MUST be followed strictly to ensure the health and well being of ALL Students.

I have read and understand the information above regarding Immunizations, Health Screenings, 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 parent/guardian agreement before accessing student immunization records within the Wyoming Immunization Registry (WyIR). Do you consent to the access of your child's immunization records? **Yes** ____ **No**____

Signature of parent/guardian: _____ Date: _____

PLEASE CONFIRM BOTH SIDES ARE COMPLETE AND SIGNED

FREMONT COUNTY SCHOOL DISTRICT NO. 2

Every Day Counts: Educate, Engage, Empower

Fremont County School District #2
Request for Administration of Medication

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: _____ Date of Birth: _____
Grade: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of medication: _____ Allergies: _____

Diagnosis: _____

Instructions: Time to be given at school: _____ Frequency: _____

Strength: _____ Dose: (mg, ml, ml/tsp, # puffs): _____ Route: _____

If PRN, for what symptoms: _____

If PRN, frequency: _____

Relevant Side effects: (please describe): _____
Please check one of the following:
Discontinue: ☐ End of school year ☐ Other (specify): _____

Authorized Prescriber's Signature: _____ Date: _____

Authorized Prescriber's Name/Title: _____ Date: _____

◆◆ **For Self – Administration ONLY** ◆◆

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

TO BE COMPLETED **FOR INHALER OR EPI-PEN** ONLY

Fremont County School District permits a student to possess and self administer asthma or anaphylaxis medication at school and at school related functions. Completion of the following information **by the authorized prescriber** acknowledges that this student has been instructed and has the skills and knowledge on self administration of this medication.

This student may carry this medication: ☐ Yes ☐ No

Authorized Prescriber's Signature: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above stated medication at school according to FCSD #2 school policy. I release FCSD #2 and their employees from any claim or liability for administering prescribed medication to this student. I HAVE READ THE MEDCATION GUIDELINES AND ASSUME THE RESPONSIBILITES AS STATED ON THIS FORM. I authorize the school nurse to communicate with the health care provider as allowed by HIPPA.

Date: _____ Signature: _____ Relationship: _____
Phone: _____

Order Reviewed by the school Nurse: _____ Date: _____

FREMONT COUNTY SCHOOL DISTRICT NO. 2

Every Day Counts: Educate, Engage, Empower

Fremont County School District #2
Request for Administration of Medication

RESPONSIBILITY OF THE PARENT/GUARDIAN

- **Whenever possible, medication should be given at home.
- **Medication WILL NOT be given until this form is completed by the parent/guardian and the authorized prescriber and is on file in the school nurse office.
- When bringing medications to school:
    a. Prescription medication (s) must be in a container labeled by the pharmacist with the student's name, prescriber's name, name of medication, dosage, route, directions for administration, conditions for storage, prescription date and expiration date. (Original pharmacy container)
    b. Over-the-counter medication(s) must be provided to the school in the original sealed container. It is also important to make sure there is a current expiration date on it. Staff may not dispense outdated medication.
    c. Antibiotics which are given three times a day are not usually given at school. Morning, after school and before bed are acceptable.
- *Students are not permitted to carry any medications,* ***including over the counter****, on a school campus.* However, an authorized prescriber, parent/guardian and school nurse may authorize a student to self-carry his/her prescribed medication, if necessary, with appropriate documentation.
- Parents/guardians may pick up unused medications from the school office during and at the close of the school year. NO medication will be sent home with your child. Medication remaining after the last day will be discarded.
    - If medication is given on an as-needed basis, specify the exact conditions or symptoms when medication is to be taken and the time at which it may be given again.
    - Unless otherwise specified, medication order is valid for the entire school year.
    - A new form is needed for ***ANY*** changes in medication, dose or time.
    - ALL MEDICATION ORDERS WILL BE RENEWED ANNUALLY.

RESPONSIBILITY OF SCHOOL NURSE/DELEGATED SCHOOL PERSONNEL

- The school nurse/delegated school staff will assume responsibility for placing medications in a locked cabinet.
- If the school nurse is not available to give medication, another delegated trained staff member will be assigned to do so.
- School nurse/delegated school staff will assist and observe the student in taking medication according to the authorized prescriber's instructions. The date and time each medication is given will be recorded on the Medication Record by the staff assisting the student in taking medication.
- The school district and its employees are not responsible for undue reaction of this medication.
- School nurse/delegated school staff may not administer any medication at times other than those specified on the authorized form. FCSD staff will not administer any product not approved by the FDA. (essential oils/drops) You may come in to do so.
- Dosage fluctuations as ordered by physician will be determined by school nurse only.

****MEDICATION ORDER FORM IS ON BACK PAGE******

Request for Records

FREMONT COUNTY SCHOOL DISTRICT NO. 2
Every Day Counts: Educate, Engage, Empower

To: Dubois K-12 School
P.O. Box 188
Dubois, WY 82513
Phone: (307) 455-5524 / Fax: (307) 455-2654
or e-mail to: jmccabe@fremont2.org

K-12 Principal: Mr. Tad Romsa

Date of request: _____ Records received: _____

Former School: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ FAX: _____

It is requested that a copy of the school records for:

Student's Legal Name: _____ Date of Birth: _____ Grade: _____

Student's Legal Name: _____ Date of Birth: _____ Grade: _____

Student's Legal Name: _____ Date of Birth: _____ Grade: _____

These records are to be released to F.C.S.D. #2. Please send all pertinent information including:

- Cumulative permanent school records
- Achievement and other standardized test results
- Attendance and discipline reports
- Health and immunization records, sports physical information
- Psychological, speech and hearing reports
- Title I
- Special education records including: active IEP and current Diagnostic Summary:
  - Please e-mail to kschueneman@fremont2.org or fax to (307) 455-2654.

_____

Parent / Legal Guardian / School Official Signature Date

No parent signature required – Wyoming Federal Statute 99.31