Registration Requirements

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

- FCSD #2 enrollment Form
- Request for records if needed
- Completed Student Health Information Form (this is 2 pages)
- Home Language Survey
- Copy of certified birth certificate online @ www.vitalchek.com
- Copy of social security card
- 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 Kindergarten Students:

- DTAP 4-5 Doses (At least one dose must be given on or after child’s 4th birthday)
- HIB Completed Valid 4 dose series
- POLIO 3-4 Doses (At least one dose must be given on or after child’s 4th birthday)
- MMR 2 Doses
- HEP B 3 Doses
- Varicella Vaccine (chicken Pox) 2 Doses or documented history of the virus. (Contact me for this form)
- Tdap/Td after 11th birthday

Immunizations may be scheduled through Fremont County Public Health 307-856-6979.
# Enrollment Form

## Student Personal Information

<table>
<thead>
<tr>
<th><strong>Student’s Legal Name</strong> (as written on birth certificate):</th>
<th>Female</th>
<th><strong>Preferred Name:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td></td>
<td>Birthplace:</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td>Grade Entering:</td>
</tr>
<tr>
<td><strong>Race:</strong></td>
<td></td>
<td><strong>Social Security Number:</strong></td>
</tr>
</tbody>
</table>

- American Indian or Alaska Native
- Asian American
- Black or African American
- Native Hawaiian or other Pacific Islander
- Not Hispanic/Latino
- Hispanic/Latino

## Family Information

**Parent/Legal Guardian Name(s):**

**Physical Address:**

**Mailing Address:**

**Home e-mail address:**

**Father’s Name:**

**Mother’s Name:**

**Father’s Employer:**

**Mother’s Employer:**

**Telephone Number:**

Please list siblings (name & age):

## Student Lives With (Check One)

- Both Mother & Father
- Mother ONLY
- Father ONLY
- Shared Custody (split between parents)
- Mother & Stepfather
- Father & Stepmother
- Other / Guardian:_____________________

If parents are separated or divorced or child lives with guardian, please provide a copy of legal documentation.

**Non-Custodial Parent’s name and address:**

**Phone:**

## Medical / Emergency Contact Information

**Emergency Contact #1**

- **Relationship to child:**
- **Telephone Number:**
- **Cell Phone Number:**

**Emergency Contact #1**

- **Relationship to child:**
- **Telephone Number:**
- **Cell Phone Number:**

**Daycare (if applicable)**

- **Telephone Number:**

**Other Person(s) Authorized to Represent Student**

- **Relationship to student:**

**Family Physician:**

- **Physician Phone Number:**

## Miscellaneous Information

**Most Recent School Attended:**

**Telephone Number:**

Has your child received any Special Services?  _______yes  _______no

Will your child require school bus transportation?  _______yes  _______no

Any previous record of expulsion or out of school suspension?  _______yes  _______no

To assure that your child is provided an appropriate education, enrollment may require a waiting period of 3-5 school days to determine residence, confirm guardianship, and review previous school records.
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
Request for Records

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:
  o Please e-mail to mgage@fremont2.org or fax to (307) 455-2654.

_______________________________________________________
Parent or Legal Guardian Signature Relationship to Student
Fremont County School District #2 School Health Information

Student Name ___________________________________________________________  Male _____ Female_____ Grade _____

Date of Birth ____________________ Parent/Guardian Name(s): ___________________________________________________________

Mother: Home Phone _______________________ Cell Phone ____________________ Work Phone _____________________

Father: Home Phone ________________________ Cell Phone ______________________ Work Phone _____________________

EMERGENCY CONTACTS (other than parents)

1. __________________________________________________ Relationship___________________ Phone Number______________
2. __________________________________________________ Relationship___________________ Phone Number______________

MEDICATION Information: List any 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 ALL allergies and type of reaction:
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

Does your child require and epi-pen for these allergies? Yes _____ No _____
Last occurrence of anaphylaxis ___________ Symptoms of an anaphylactic reaction ______________________________________________________________________________________

ASTHMA:
Does your child have asthma or difficulty breathing with exercise? 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 _______

OTHER MEDICAL ISSUES

History of seizures? Yes_____ No_____ Date of last seizure ______________________________
Frequent headaches or migraines? Yes_____ No_____ Best treatment when they occur? ______________________________
Hearing loss? Yes _____ No_______  Diabetes? Yes _____ No_______
Speech difficulty? Yes_____ No_____  Participated in speech therapy? 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 the school. Your child will be given the correct dose based on their age and weight. 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%, etc.  Yes _____ No _______

I give permission for the school nurse or other designated staff members to dispense the above named medication to my child as they need them throughout the school day.

________________________________________________________________________________________
Signature of Parent/Guardian Date Contact Phone Number

PLEASE COMPLETE AND SIGN BOTH SIDES
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. School Immunization Requirements for 2019-2020:

Prior to starting Kindergarten: DTaP - 5 doses, Hib - Completed Valid Series (1-4 doses), Hep B - 3 doses, MMR - 2 doses, Polio (IPV) - 3-4 doses at least 1 dose must be given on or after the 4th birthday, Varicella (Chickenpox) - 2 doses or documented history of disease.

11 years of age and older: Tdap booster - 1 dose

HEALTH SCREENINGS

Health screenings are an opportunity for you to gather information regarding your child’s health. Please remember these are only screenings. Some results may include the need for your child to receive a follow-up examination by a health care provider. Please remember health screenings do not replace regular care provided by professional health care providers.

The school nurse will screen selected grades for vision and hearing. Upon completion, results are mailed home.

MEDICATION POLICY

If your child requires medications 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.
3. Students taking an over the counter medication that has been sent from home, must bring the medication in the manufacturer’s original container. Do not send medications in small baggies or plastic containers.
4. Students must take all medication in the presence of designated school personnel. EXCEPTION: SEE #6 below*
5. All medication will be stored under lock in the nurses. *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.

PLEASE SIGN AND RETURN WITHIN 2 SCHOOL DAYS

I have read and understand the information above regarding medications given at schools, health screenings and the school medication policy:

____________________________________________________________  ______________________________________
Signature of parent/guardian  Date

PLEASE COMPLETE AND SIGN BOTH SIDES
LUNCH ACCOUNTS/PAYMENT FOR LUNCHES

Fremont County School District #2 discourages households and staff from charging meal account in a negative balance. Student and Staff will continue to receive a regularly scheduled meal in their account has a negative balance. The meal account will be charged as normal. Communication will be focused between the school and the household rather than the student. Payments to household/staff accounts can be made online using VANCO via Infinite Campus or in the k-12 office. Students may continue receiving meals with a negative lunch balance so long as parents/guardians are taking action to rectify their account. A copy of this policy will be provided to every household/staff at the beginning of each school year and to all new students/staff.

Adoption Date: September 20, 2011
Amended Date: March 26, 2019