Bowie Unified School District #14

Wendy Ann Conger, Superintendent
P.O. Box 157, 315 W. 5th Street Bowie, AZ 85605
(520) 847-2545 Fax (520) 847-2546
Bowie Elementary School District Gymnasium Bowie High School
Mary G Doyle Building Bruce E. Brown Gym Sen. A. R. Spikes Building
*Home of the **Panthers***

STUDENT ENROLLMENT FORM

Date: _____ Grade Entering: _____

Name: _____ _____ _____
(Last) (First) (Middle)

Birthdate: ____ / ____ / ____ Place of Birth: _____

☐ Male ☐ Female Social Security Number: _____ - _____ - _____

Race/Ethnicity: ☐ White ☐ Hispanic ☐ Black ☐ Indian ☐ Asian ☐ Other

Primary Language:

☐Yes ☐No The language most often spoken in the Student's home is other than English, regardless of the language spoken by the student.

☐Yes ☐No The language most often spoken by the student is other than English.

☐Yes ☐No The student's first acquired language is other than English.

Father's Name: _____ Mother's Name: _____
Phone # _____ Phone # _____
Guardian: _____ Relationship: _____
Phone # _____
Residence Address: _____
Mailing Address: _____
Emergency Contact: _____ Phone#: _____
Parents/Guardians Employer: _____
School Student Last Attended: _____
Address of Last School: _____

☐ Yes ☐ No Has the student been to an Arizona School before?

FOR OFFICIAL USE ONLY

Student Enrollment Date: _____ Initials: _____
Date Entered into SMS: _____ Initials: _____

Please indicate if the child has Special Education needs:

[ ]YES [ ]NO LEARNING DISABILITY (LD)
[ ]YES [ ]NO EMOTIONAL BEHAVIOR DISABILITY (EBD)
[ ]YES [ ]NO COGNITIVE DISABILITY (CD)
[ ]YES [ ]NO SIGNIFICANT DEVELOPMENT DELAY
[ ]YES [ ]NO AUTISM
[ ]YES [ ]NO OTHER HEALTH IMPAIRMENT
[ ]YES [ ]NO HEARING HANDICAP
[ ]YES [ ]NO SPEECH/LANGUAGE HANDICAP
[ ]YES [ ]NO VISION HANDICAP
[ ]YES [ ]NO PHYSICAL HANDICAP

DOES STUDENT HAVE:

[ ] ADD/ADHD
[ ] DEPRESSION
[ ] EPILEPSY
[ ] ALLERGY
[ ] ASTHMA
[ ] DIABETES
[ ] LIFE THREATENING
CONDITION_____
[ ] OTHER:_____

IS STUDENT UNDER MEDICAL SUPERVISION AND/OR ON MEDICATION:
[ ]YES [ ]NO

IF YES,
DESCRIBE:_____

_____
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

ARIZONA STATE ARS R7-2-401

REQUIREMENTS FOR PRE-SCHOOLERS THROUGH 21 YEARS OF AGE

Does your child socialize well with other people & children?	[ ]Yes [ ]No
Does your child seem extremely shy or withdrawn?	[ ]Yes [ ]No
Does your child remember things well?	[ ]Yes [ ]No
Does he/she forget frequently and has to be told things over and over?	[ ]Yes [ ]No
Does your child see well?	[ ]Yes [ ]No
Does he/she have to get very close to see?	[ ]Yes [ ]No
Does your child hear well?	[ ]Yes [ ]No
Do you have to repeat or face your child in order for him/her to respond?	[ ]Yes [ ]No
Does your child speak well, use complete sentences, and enunciate clearly?	[ ]Yes [ ]No
Does he/she use “baby talk”, use only single words and phrases, or have a speech impediment?	[ ]Yes [ ]No
Are there any physical handicaps or problems?	[ ]Yes [ ]No

HEALTH OFFICE

STUDENT NAME:_____

Dear Parent/Guardian,
When your child is referred to the health office for injury illness, non-medicinal techniques such as cool packs, warm packs, rest, etc. are attempted before giving medications. In the event that these techniques do not work, medications are available with your written permission. Please review the following medications.

PLEASE INITIAL ONLY THE MEDICATIONS YOU WANT YOUR CHILD TO TAKE.

[ ] Tylenol	[ ] Children's Tylenol
[ ] Cough Drops	[ ] Motrin/Ibuprofen
[ ] Pepto Bismol	[ ] Eye Drops
[ ] Neosporin	[ ] Hydrogen Peroxide
[ ] First Aid Spray	[ ] Rubbing Alcohol
[ ] Rolaids/Tums	[ ] Adult Allergy
[ ] Children's Allergy	

SIGNATURE OF PARENT/GUARDIAN DATE

STUDENT NAME_____

RE: Emergency medical treatment
for:_____

Name of Student

TO WHOM IT MAY CONCERN:

I, _____, custodial parent or legal guardian of _____, whose date of birth is _____
hereby give permission to any emergency medical technician, nurse, ophthalmologist , physician or physician's assistant, to treat my child for any illness, trauma, accident or medical emergency he/she may experience while attending school at _____ or while traveling with her/his class on field trips or to attend sporting events during _____school year. I also authorize the principal, instructor, coach or sponsor to make medical decisions regarding my child's medical condition and decisions which have been made as soon as is reasonably possible, but that treatment will not be delayed for that reason. I agree that I will be financially responsible for the emergency medical treatment incurred.

My child:

[ ] Is not allergic to any medications and has no other allergies.

[ ] Has the following allergies:_____
_____

[ ] Is taking the following medicatio_____
_____

Signature of Parent/Guardian Date

Mailing Address Town State
Zip

Telephone numbers at which I may be reached at:
Home_____

Work_____

In the alternative, you may reach _____, at the following telephone numbers: Home _____
Work_____

HEALTH INFORMATION SHEET

Child's Name:_____ Sex:_____ Birthdates:_____

Home Address:_____ Phone :_____

Parent/Guardian:_____ Social Security #:_____

Occupation:_____ Work Phone: _____
Local Person to notify in an emergency:

Name:_____ Phone number:_____

Name of Local doctor_____ Phone number:_____
Has your child had any of the following? (Date or child's age at onset)?

Anemia		Growth Problems		Pneumonia	
Asthma		Hernia		Pregnancy	
Broken Bones		Heart Disease		Rheumatic Fever	
Chickenpox		Hepatitis		Scarlet Fever	
Convulsions		Influenza		Tonsillitis	
Diabetes		Meningitis		Tuberculosis	
Eczema		Mental Heal		Valley Fever	
Epilepsy		Mononucleosis		Operations	
Other					

Is your child going to a hospital, clinic or doctor now? [ ]YES [ ]NO
Reason_____
Where_____

Is your child allergic to anything such as foods, plants, insects, or medicine? [ ]YES [ ]NO
What_____
_____
Is reaction severe enough to require immediate medical attention or medication? [ ]YES [ ]NO

Is your child able to participate in Physical Education? [ ]YES [ ]NO
Does your child have any of the following?

Frequent colds		Unusual mood problem	
Frequent sore threat		Over/under weight problems	
Ear infections		Speech problems	
Frequent ear aches		Hearing problems	
Frequent tooth aches		Vision problems	
Frequent pain in legs		Wears glasses, contacts	
Frequent stomach aches			

Please list any additional information that would help the nurse in providing good health care to your child._____

Patent/Guardian Signature_____Date_____

Bowie Unified School District #14
ELECTRONIC INFORMATION SERVICES USER AGREEMENT

Please read this document carefully. When signed it becomes a blinding agreement.

Terms and Conditions

Acceptable use- I will use the service to support personal educational objectives within the educational goals and objectives of the School District. Inappropriate use may result in cancellation of use of information service and/or appropriate disciplinary action. I will not submit, publish, display, or retrieve materials forbidden by statutes, laws, or District policies and regulations.

Personal responsibility- I will report any misuse of the information service to a parent, teacher, or the system administrator, as appropriate.

I understand that many services and products are available for a fee and acknowledge the responsibility for any expenses incurred without District authorization.

Network etiquette- I am expected to abide by the generally acceptable rules of network etiquette. Therefore, I will:

- Be polite and use appropriate language. I will not send, or encourage other to send, abusive massages
- Respect privacy. I will not reveal any home addresses or personal phone numbers.
- Avoid disruptions. I will not use network in any way that would disrupt use of the systems by others.

Services- The School District specifically denies and responsibility for the accuracy of information. While the District will make an effort to ensure access to proper materials, the user has the ultimate responsibility for how the electronic information service (EIS) is used and bears the risk of reliance on the reliance on the information obtained.

Student or District employee- Read and Sign Below

I have read and agree to abide by the School District policy and regulations on appropriate use of the electronic information system, as incorporated herein by reference. I understand and will abide by the provisions and conditions indicated. I understand that any violations of the above terms and conditions may result in disciplinary action and the revocation of my use of information services.

_____ _____

User's Name (print) User's Signature

School_____ Grade (if a student)_____

A student must also have the signature of a parent or guardian who has read and will uphold this agreement.

Parent or Guardian Cosigner – Read and Sign Below

As the parent or guardian of this student, I have read this agreement and understand it. I understand that it is impossible for the School District to restrict access to all controversial materials, and I will not hold the District responsible for the materials acquired by use of the information services. I also agree to report any misuse of the information services to a School District administrator. (Misuse may come in many forms but can be viewed any messages sent or received that indicate or suggest pornography, unethical or illegal solicitation, racism, sexism, inappropriate languages, or other issues described in the agreement.

I accept full responsibility for supervision if, and when, my child's use of the information services is not a school setting. I hereby give my permission to have my child use

Parent/Guardian's Name (print) _____

Parent/Guardian's Signature_____Date: _____

CONSENT TO DISTRICT'S USE OF STUDENT PHOTOGRAPH

ON SCHOOL WEBSITE

Student name:_____

Student's School:_____

Parents/Legal
Guardian:_____

Address and telephone:_____

_____

The Bowie Unified School District would like to post the student's photograph on the Internet at the school or District website in order to (reason):

_____

_____

We realize that many people have concerns about privacy and the Internet. For that reason, we will not use the student's photograph on our website without your express written consent.

We therefore request that you indicate your preference on the bottom of the attached form, sign it, and return it to the school. If you have any questions you may call the school at 520-847-2545.

After carefully considering the District's request to use the student's photograph and name on the District website, the above-name parents or guardians and the student (or the student alone if over 18) hereby give permission to the District to use the student's photograph on the school or district web pages as part of the World Wide Web (WWW)—a part of the Internet.

We understand that we may revoke this authorization at any time except when action has already been taken. We further understand that this revocation must be in writing and must specify the date of revocation.

_____

Signature of Parent/Guardian Date

_____

Signature of Student (if over 18 years of age) Date

Bowie Unified School District #14

Wendy Ann Conger, Superintendent

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REQUEST FOR STUDENT EDUCATION RECORDS

Student Name:_____

___/___/_____ _____

DOB Grade

Request From:_____

School or Agency

_____

Address City/State/Zip

_____ _____

Phone Fax Phone

Records Requested:

- SAIS Number
- Attendance Records
- Birth Certificate
- Transcripts and/or Grades
- Withdrawal Form/Grades
- Promotion/Retention Records
- Health/Immunization Records
- Screening Results
- Testing Records/AIMS Scores
- Suspensions/Expulsion
- 504 Plan

SPECIAL EDUCATION RECORDS

- IEP
- MET
- Psychological Records
- Other Records (if available)

_____

Registrar, Bowie USD #14

I, _____authorize release of records listed above to the party

(Parent/Guardian Name)

named above. I am aware of my rights (FERPA) to review the records and receive a copy at my expense, if I so request.

_____ _____

(Signature of Parent/Guardian) (Date)