BLACK OR BLUE INK ONLY

FOWLER SCHOOL DISTRICT #45 REGISTRATION FORM

FOR OFFICE USE ONLY

RETURNING STUDENT: Yes ❒ No ❒
TEACHER_____
GRADE_____
ENROLL DATE_____
BUS_____

ENROLLMENT CODE_____
PRIMARY LANG_____
DISTRICT ID#_____
SAIS ID#_____

STUDENTS LEGAL LAST NAME	FIRST NAME	MIDDLE NAME	BOY ❒ GIRL ❒

ETHNICITY Is this student Hispanic/Latino? Yes ❒ No ❒

RACE What is the student's race? *(Please check at least one. Mark all that apply)*
❒ WHITE ❒ BLACK or AFRICAN AMERICAN ❒ ASIAN
❒ AMERICAN INDIAN OR ALASKA NATIVE ❒ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER

STREET ADDRESS	CITY/ZIP CODE	HOME/MOBILE PHONE NUMBER

BIRTHDATE	BIRTH PLACE	BIRTH CERTIFICATE ❒ YES ❒ NO	HAVE ATTENDED THIS DISTRICT BEFORE? ❒ YES ❒ NO

FATHER'S NAME	OCCUPATION/EMPLOYER	WORK PHONE NUMBER
MOTHER'S NAME	OCCUPATION/EMPLOYER	WORK PHONE NUMBER
SCHOOL LAST ATTENDED	ADDRESS	CITY/STATE/ZIP

FATHER'S EMAIL:	MOTHER'S EMAIL:

PRIOR TO THIS YEAR, NUMBER OF SCHOOL YEARS IN ATTENDANCE IN THE UNITED STATES_____

SPECIAL EDUCATION PROGRAMS

Yes	No		Date
❒	❒	Resource	_____
❒	❒	Self-Contained	_____
❒	❒	Speech	_____
❒	❒	O.T./P.T.	_____
❒	❒	Special Transportation	_____
❒	❒	Other_____	_____

SPECIAL PROGRAMS

Yes	No		Date
❒	❒	Title 1_____	_____
❒	❒	Gifted	_____
❒	❒	ESL (Bilingual)	_____
❒	❒	Migrant	_____
❒	❒	Other_____	_____
		_____	_____

MEDICAL ALERT
Is child currently on medication? Yes ❒ No ❒

What type of medication?
_____

Specify special medical conditions:
_____
_____
_____

ADDITIONAL INFO

	Yes	No
Custody other than parent?	❒	❒
Parent in Military?	❒	❒

Responses to these statements will be used to determine whether your child will be assessed for English Language Proficiency.

1. What is the primary language used in the home regardless of the language spoken by the student? _____
2. What is the language most often spoken by the student? _____
3. What is the language that the student first acquired? _____

DID THE FAMILY MOVE FOR THE PURPOSE OF SEEKING OR OBTAINING TEMPORARY OR SEASONAL EMPLOYMENT IN AGRICULTURE, DAIRY WORK OR A RELATED FOOD PROCESSING ACTIVITY? YES ❒ NO ❒

WHAT LANGUAGE WOULD YOU PREFER WHEN RECEIVING WRITTEN COMMUNICATION FROM THE SCHOOLS?
_____

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**

Rev 2/2019 VL

EXHIBIT

ADMISSION OF RESIDENT STUDENTS

RESIDENCY DOCUMENTATION FORM

Student _____ School _____

School District or Charter Holder _____

Parent/Legal Guardian _____

As the Parent/Legal Guardian of the Student, I attest that I am a resident of the State of Arizona and submit in support of this attestation a copy of the following document that displays my name and residential address or physical description of the property where the student resides:

_____ Valid Arizona driver's license, Arizona identification card or motor vehicle registration

_____ Valid U.S. passport

_____ Real estate deed or mortgage documents

_____ Property tax bill

_____ Residential lease or rental agreement

_____ Water, electric, gas, cable, or phone bill

_____ Bank or credit card statement

_____ W-2 wage statement

_____ Payroll stub

_____ Certificate of tribal enrollment or other identification issued by a recognized Indian tribe that contains an Arizona address

_____ Documentation from a state, tribal or federal government agency (Social Security Administration, Veteran's Administration, Arizona Department of Economic Security)

_____ I am currently unable to provide any of the foregoing documents. Therefore, I have provided an original affidavit signed and notarized by an Arizona resident who attests that I have established residence in Arizona with the person signing the affidavit.

_____ _____

Signature of Parent/Legal Guardian Date

Reproduction of ADE FORM 2306606 which may be used in lieu of this document.

FOWLER ELEMENTARY SCHOOL DISTRICT NO. 45

1617 S. 67th Avenue, Phoenix, AZ 85043 Phone: (623) 707-4500 Fax: (623) 707-4560
www.fesd.org

Ignacio Fernandez
Governing Board President

Peggy Eastburn
Governing Board Clerk

Francisca Montoya
Governing Board Member

Marvene Lobato
Superintendent

Nora Ulloa
Asst. Superintendent Business Services

Cindy Bradley
Academic Services

Karen Watkins
Curriculum

Jim Chesnik
Facilities

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Early Childhood

Jonathan Rohloff
Research & Data Analysis

Rose Ann Wastjer
Student Services

Lane Blake
Technology

Leticia Valenzuela
Transportation

AFTERSCHOOL TRANSPORTATION

Student's Name: _____

My Child Attends One of the Following:

☐ Western Valley Extended Daycare (Review Packet for Information)

Ride The Bus To:

Sitter:.....Name:_____

Address:_____

Phone #:_____

Route Stop:_____

Home:.....Address:_____

Phone #:_____

Route Stop:_____

Picked Up By:

Name:_____

Address:_____

Phone #:_____

Relationship to Student:_____

Walk Home

Home Address:_____

Phone #:_____

Parent/Guardian Signature: _____ Date: _____

State of Arizona
Department of Education

Office of English Language Acquisition Services

Primary Home Language Other Than English (PHLOTE)
Home Language Survey
(Effective April 4, 2011)

These questions are in compliance with Arizona Administrative Code, R7-2-306(B)(1), (2)(a-c).

Responses to these statements will be used to determine whether the student will be assessed for English Language Proficiency.

1. **What is the primary language used in the home regardless of the language spoken by the student?**

2. **What is the language most often spoken by the student?**

3. **What is the language that the student first acquired?**

District

Student Name _____ Student ID

Date of Birth____ SSID _____

Parent/Guardian Signature _____ Date

District or Charter _____

School _____

Please provide a copy of the Home Language Survey to the EL Coordinator/Main Contact on site.

In AzEDS, please indicate the student's home or primary language. (Revised 01-2019)

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Special Education Registration Placement Form

Student's Name _____Date of Birth _____

Attending School _____

To provide continuity in your child's educational program, it is important that we be made aware of any special help he/she may have received or programs they have participated in at his/her previous school.

Please provide the following information to help us provide appropriate placement.

□ My child has not received any special education services.

□ My child has had special testing:

Reason why _____

My child has received special education services as checked below:

Special Education Programs:

□ Resource *(academic areas such as consult, inclusion, reading, math, and writing)*

□ Self-Contained

□ Speech Therapy

□ Occupational or Physical Therapy

□ Vision Services

□ Hearing Services

□ My Child has a 504 plan.

□ Other _____

_____ _____

Parent/Guardian Signature Date

Fowler School District No. 45

STUDENT RESIDENCY QUESTIONNAIRE

This form is intended to address the requirements of the McKinney-Vento Act 42 U.S.C. 11435, which is also known as Title X, Part C, of the No Child Let Behind Act. The answers to the questions below assist in determining if the student meets the eligibility criteria for services provided under the McKinney-Vento Act.

School Campus:	**School Year:**	
Student Name:	**Date of Birth:**	**Grade:**
Current Address (Include City, State and Zip):	**Phone Number:**	**Cell Number:**
Last School Attended (Include City, State and Zip):	**Last Date Attended:**	**Grade Level:**

Name of person with whom student resides:

I am the:

❒ Parent ❒ Caregiver(s) who are not legal guardian(s) (Examples: friends, relatives, parents of friends, etc.)

❒ Legal Guardian (s) ❒ Other_____

1. Is the student's home address a temporary living arrangement? ❒ Yes ❒ No
   How long has the student been at this address? _____*Months,* _____*Years*

2. Is this a temporary living arrangement due to loss of housing or economic hardship? ❒ Yes ❒ No

3. Where is this student currently living? ***(check the box that applies)***

   ❒ In my own home or apartment, in Section 8 housing, or in military housing with parent(s), legal guardian(s), or caregiver(s).

   ❒ Student is living with family or friends due to: ***(check the box that applies)***
   ❒ Convenience (long-term sharing expenses)
   ❒ Necessity – Temporary, financial crisis/loss of housing that made living together the only option
   *How long have you shared the residency at the same address with the same people?*_____
   *How many people total live in the home?*_____ *How many bedrooms?*_____ *How many bathrooms?*_____
   *Do you need to vacate this residence in the next 6 months?*_____

   ❒ In a motel/hotel
   Name/Address_____

   ❒ In a shelter
   Name/Address_____

   ❒ Unsheltered (i.e. car, parks, garage, campsite, any building without water or electricity)

   ❒ Foster Care

   ❒ I am by myself living temporarily in _____(not in the legal custody of an adult)

   ❒ Foster Care (Other)_____

4. Please provide the following information for siblings (brothers and/or sisters) of the student:

Name	Date of Birth	School	Grade

The undersigned certifies that the information provided above is accurate.

_____ _____

Parent/Guardian/Caregiver Signature Date

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Request for Release of Student Records

STUDENT: _____ _____ DOB: _____ GRADE: _____

The parent/guardian who has signed below has been informed of this transfer request and grants permission for any and all educational information to be sent to the school listed above.

Please include the following information:

- Official Withdrawal Form
- Report Cards
- Birth Certificate
- Immunization/Health Records
- Attendance Records
- Disciplinary/Incident Reports
- All Test Scores (AIMS, AZELLA etc.)
- Parental Custody
- Other _____

Please complete the information below:

Student's previous school information:

_____
School Name

_____
School Address

_____
City State Zip Code

_____
School Telephone Number School Fax Number

_____
Signature of Parent/Guardian Date

For office use: ---------- _____

1st Request Date:__ _
Staff Initial _

2nd Request Date:____ _
Staff Initial _____

3rd Request Date: ____
Staff Initial ___

PLEASE PRINT

SCHOOL: _____
TEACHER: _____
(STAFF USE ONLY)

FOWLER DISTRICT EMENRGENCY CARD

STUDENT INFORMATION:

Last Name	First Name	Middle Name	Date of Birth	Grade:	Age	Gender ☐ Male ☐ Female

Address	Apt #	City	State	Zip Code	Home Phone

Please Check One: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian

Last Name	First Name	Place of Employment	Work Phone	Cell Phone

E-Mail

Please Check One: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian

Last Name	First Name	Place of Employment	Work Phone	Cell Phone

E-Mail

EMERGE NCY CO NTACTS: List THREE (3) persons below who will assume temporary care or responsibility for your child in case of an emergency and/or illness.

Last Name	First Name	Relationship to Student	Home Phone	Cell Phone
Last Name	First Name	Relationship to Student	Home Phone	Cell Phone
Last Name	First Name	Relationship to Student	Home Phone	Cell Phone

Are there any legal circumstances school personnel should be aware of? ☐ No ☐ Yes If YES, please provide the school with custody or court records

List the first and last names of all brothers and/or sisters, including step and/or half brothers and sisters - NOT emergency or pick up contact

Name	Age	Name	Age:
Name	Age	Nam	Age

School: _____
(STAFF USE ONLY)

FOWLER SCHOOL DISTRICT
STUDENT HEALTH HISTORY UPDATE

Name	Date of Birth	Grade	Age	Gender ☐ M ☐ F
Parent/Guardian	Home Phone		Cell Phone	
Email				Date
Physician(s)	Phone	Hospital Preference		Insurance Company

Has your child ever:	**YES**	**NO**	**If YES, please explain and include date:**
Has an ongoing medical/chronic health condition	☐	☐	
Has a medical 504 or I.E.P	☐	☐	
Had allergies	☐	☐	☐ Food ☐ Environmental ☐ Insect ☐ Medication ☐ Other:_____
Been hospitalized	☐	☐	
Had an operation/surgery	☐	☐	
Had an injury requiring an emergency room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion, had a serious head injury or traumatic brain injury (TBI)	☐	☐	
Had a convulsion/seizure	☐	☐	☐ emergency medication:_____
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If YES, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/ Trouble Breathing/ RAD
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes ☐ Insulin
- ☐ Ear Infections
- ☐ Cancer
- ☐ Epilepsy
- ☐ Hemophilia
- ☐ G.I. Conditions (ulcer, reflux, IBS) ☐ g-tube
- ☐ Headaches/Migraines
- ☐ Heart Conditions ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Mental Health Condition: (Depression, Eating Disorder, Anxiety, OCD, ODD, Bipolar, Mood Disorder, etc...) _____
- ☐ Scoliosis
- ☐ Single Organ Transplant ☐ kidney ☐ testicle
- ☐ Skin Condition/Eczema
- ☐ Speech Condition
- ☐ Urinary condition
- ☐ Hypoglycemia
- ☐ Multiple Sclerosis
- ☐ Other:_____

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at School	☐	☐	
Taken at Home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or Outside of School	☐	☐	☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other:_____
TREATMENTS	**YES**	**NO**	
During or Outside of School	☐	☐	☐ Insulin/blood glucose monitoring ☐ Inhaler/nebulizer/peak flow monitoring ☐ Special diet ☐ Diagnosed allergy needing emergency medication

Is there any condition that would prevent your child from participating in physical education or sports?
☐ NO ☐ YES: _____

Please list any additional concerns: _____

PLEASE CONTINUE ON BACK SIDE

The School Nurse/Principal/Principal Designee has my permission to treat my child for any illness or minor injuries. This includes assistance giving the following medications: topical oral pain medication, antacid, antiseptic eye wash & drops, anti-itching lotion, topical throat spray, generic Tylenol, ibuprofen, antibiotic ointments, hydrogen peroxide, cough syrup, throat lozenges, etc.

List any known food and/or medication allergies:

Parent/Guardian Signature:_____ Date:_____

If I cannot be contacted, I hereby give authorization to any hospital or medical profession to render immediate aid to my child as might be required for health and safety. It is understood that the expense of this service would be accepted by me.

Parent/Guardian Signature:_____ Date: _____

Hearing and Vision screenings will be conducted upon request. If you DO NOT want your child screened, please notify our health office in writing.

Please return to Health Office- If you need to discuss an Individual Healthcare Plan, email district nurse at judavis@fesd.org or call 623-707-2103 to make an appointment.