

**Auburn Public Schools**  
**New Student Enrollment/Emergency Form**

**Enrollment Date** \_\_\_\_\_ **Start Date** \_\_\_\_\_ **Section(pre-k only)** \_\_\_\_\_

Student's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Social Security: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Birthplace: \_\_\_\_\_  
(optional)

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ School District of Residence: \_\_\_\_\_

Grade Level (Circle): Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12 Gender (Circle): M / F

What language did the student first learn to speak? \_\_\_\_\_

What language is spoken most often by the student? \_\_\_\_\_

What language does the student most frequently use at home? \_\_\_\_\_

**Is this student Hispanic/Latino? (Choose only one)**

- No, not Hispanic/Latino**  
 **Yes, Hispanic/Latino** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

**What is the student's race? (Choose one or more)**

- American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America -- including Central America--and who maintains tribal affiliation or community attachment.)  
 **Asian** (A person having origins in any of the peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Phillipine Islands, Thailand, and Vietnam.)  
 **Black or African American** (A person having origins in any of the black racial groups of Africa.)  
 **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)  
 **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Mother: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Employer/Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Employer/Phone: \_\_\_\_\_

With whom does the student reside? \_\_\_\_\_

**Non-Custodial Parent to Receive School Mailings**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Email: \_\_\_\_\_

**Previous School Information**

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Does your child require any special services

(mark all that apply)

City/State/Zip: \_\_\_\_\_  Speech  Title Math/Reading

Phone \_\_\_\_\_ Fax \_\_\_\_\_  Special Education  Other

**Emergency Contact Information**

In case of illness or injury office personnel will first try to reach parents. If parent's cannot be reached, they will then try the below emergency numbers. It is the responsibility of the person contacted to inform the parent(s) that the child is in their care. (MUST BE LOCAL)

1. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

2. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

3. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please Turn Over and Complete the Back**

## Health History For Permanent Health Record

\*If you are moving in from out of State; Nebraska Law requires the student to get a physical and vision evaluation.

Pertinent medical information may be shared with staff members that work with my child

Yes \_\_\_\_\_ No \_\_\_\_\_

What illnesses, injuries, and operations has your child had? (Include childhood diseases and allergies)

\*please note age or date

Appendicitis _____	Asthma _____	Bronchitis _____
Convulsions _____	Diabetes _____	Measles red _____ 3day _____
Eczema _____	Ear Infections _____	Epilepsy _____
Fainting _____	Frequent Headaches _____	Tuberculosis(self) _____ (family) _____
Heart _____	Hepatitis _____	Chicken pox _____
Mumps _____	Polio _____	Pneumonia _____
Scarlatina _____	Tonsillitis _____	Stomach Ulcers _____
Whooping Cough _____	Hypertension _____	
Allergies _____		Other _____

Does the student have any physical defects, handicaps or restrictions on physical activity?

Wear Glasses \_\_\_\_\_ Wears Contacts \_\_\_\_\_ Hearing Problems \_\_\_\_\_

Have an inhaler at school? \_\_\_\_\_

Does he/she take any medication regularly? \_\_\_\_\_ If yes, what/why \_\_\_\_\_

Family Physician \_\_\_\_\_

Family Dentist \_\_\_\_\_

### **Medications**

Any prescription medication your child may need to take at school must be sent in the original prescription bottle, accompanied by a note signed by the parent stating what is to be given, amount to be given, times to be given, and the reason the medication is to be given. **Medications will not be given without the above information.** The over the counter medications District #29 will have available are Regular Tylenol, Motrin, Tums, Calamine lotion, cough drops, Antibiotic cream ( or any of its equivalents).

Tylenol	Yes _____	No _____
Tums	Yes _____	No _____
Calamine Lotion	Yes _____	No _____
Cough Drops	Yes _____	No _____
Motrin	Yes _____	No _____
Antibiotic cream	Yes _____	No _____

\_\_\_\_\_  
Parent/Guardian Signature/Date

### **Permission to be Photographed**

I give permission for my child to be photographed, recorded, or digitally taped while participating in school related activities. The images may be used in news articles, on the school's web site or in other School District#29 publications. Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature/Date