

School Entrance Form

Midland Public Schools
Midland, MI

**PLEASE PRINT ALL INFORMATION
ON BOTH SIDES OF THIS FORM**

For School Use Only

Teacher Number	Room No.	Residency verified by	Resident Dist.	Student Number
Entrance Date	Grade	Date	Census Area	DOB Verified by

Student Information

First Name	Middle Name	Last Name
To be called (nickname)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Multiple Birth (Twin, Triplet, etc)		
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White/Non Hispanic <input type="checkbox"/> Asian American		Place of Birth
		Country of Citizenship
Home Language Information		Alien Registration Number
1. Is your student's primary language a language other than English? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please Specify _____		Entry date into U.S. (if within 12 months)
2. Is there a language other than English spoken regularly in the home? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please Specify _____		
Do you wish to have your student tested for potential tutoring in English as a second language? <input type="checkbox"/> Yes <input type="checkbox"/> No, we refuse ESL Services		

Physical Address

Mailing Address (if different than physical address)

Apt Number	Street	Apt Number	Street	P.O. Box
City	Zip	City		
Transportation <input type="checkbox"/> To school <input type="checkbox"/> From school <input type="checkbox"/> Special needs	State		Zip	
Housing Arrangement <input type="checkbox"/> Permanent/Regular Housing <input type="checkbox"/> Living with Friend or Relative <input type="checkbox"/> Shelter <input type="checkbox"/> In Transition	Home Phone			

Last School Attended

School Name	Street Address	City
State	Zip	Withdraw Date
Type of School <input type="checkbox"/> Public <input type="checkbox"/> Private	Enrolled in <input type="checkbox"/> Regular Education <input type="checkbox"/> Special Education	

Custodial Guardian

First Name	Middle Name	Last Name
Relationship to student (father, mother, etc)	Employer	Email Address
Education Level Completed	Apt Number	Street
P.O. Box	City	State
	Zip	Currently serving in the Military? <input type="checkbox"/> Yes
Home Phone	Work Phone	Extension
	Cell Phone	Pager

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Education Level Completed	Apt Number	Street
P.O. Box	City	State
	Zip	Currently serving in the Military? <input type="checkbox"/> Yes
Home Phone	Work Phone	Extension
	Cell Phone	Pager

Non-Custodial Guardian

First Name	Middle Name	Last Name
Relationship to student (father, mother, etc)	Employer	Email Address
Education Level Completed	Apt Number	Street
P.O. Box	City	State
	Zip	Currently serving in the Military? <input type="checkbox"/> Yes
Home Phone	Work Phone	Extension
	Cell Phone	Pager

Notes

Other children in household (please begin with oldest child)

Full Name (Last, First, Middle)	Gender	Date of Birth	Age	Grade
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Emergency Contact

First Name		Middle Name		Last Name	
Relationship to student (uncle, aunt, family friend, etc)		Apt Number	Street		
P.O. Box	City			State	Zip
Home Phone		Work Phone	Extension	Cell Phone	Pager

Emergency Contact

First Name		Middle Name		Last Name	
Relationship to student (uncle, aunt, family friend, etc)		Apt Number	Street		
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Emergency Contact

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P.O. Box	City			State	Zip
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Health/Medical Information

Family Doctor		Phone
Immunizations: Please attach current immunization records. We must have current immunization information or a waiver to complete your students registration.	Allergies or reactions to: <input type="checkbox"/> Medication _____ <input type="checkbox"/> Insect Stings _____ <input type="checkbox"/> Foods _____ <input type="checkbox"/> Seafood _____ <input type="checkbox"/> Other _____	
	Medical devices: <input type="checkbox"/> Brace <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing Aide <input type="checkbox"/> Other _____	

Health alerts, Please explain:

<input type="checkbox"/> Vision	<input type="checkbox"/> Cardiac	_____
<input type="checkbox"/> Hearing	<input type="checkbox"/> Cystic Fibrosis	_____
<input type="checkbox"/> Speech	<input type="checkbox"/> Immuno-Deficiency	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Neurological	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Orthopedic	_____
<input type="checkbox"/> Blood	<input type="checkbox"/> Psychological	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Sickle Cell Anemia	_____
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Other	_____

Parent/Guardian Signature	Date
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