

Birth Certificate _____
Immunizations _____
H & V _____

Date: _____

FOREST PARK SCHOOL DISTRICT
Enrollment Blank

Grade: _____

Pupil's Name _____
Last First Full Middle Name

Address _____ Phone _____
Street / P. O. Box Number City

Birth date _____ Age _____ Birthplace _____

Soc. Security No. _____ Ethnic Group/ Racial Information* _____

*Although optional, the ethnic/racial information is requested to fulfill obligations to the State of Michigan.

	Mother (include maiden name)	Father	Guardian
Parents	_____	_____	_____
Birthplace	_____	_____	_____
Educational Status	_____	_____	_____
Occupation	_____	_____	_____
Marital Status	_____	_____	_____

With Whom Does the Child Reside? _____

Names of other children at home:	Birth Date
_____	_____
_____	_____

If you are transferring from one school to another, please list the following information of last school attended:

_____	_____
School Name	Phone Number
_____	_____
Address	FAX Number

City, State, Zip Code	

IN CASE OF EMERGENCY: Person to be contacted in the event parents cannot be reached:

Name _____ Phone _____

Parent Signature: _____ Date: _____

Please complete the health history for your child on the next page.

FOREST PARK SCHOOL DISTRICT

801 Forest Parkway
Crystal Falls, MI 49920

HEALTH HISTORY OF A STUDENT ENTERING SCHOOL

The following information is requested so that it can be placed in the child's personal school record for future reference.

Student's Name _____ Birth date _____ Sex _____
Address _____ Phone _____ Parent _____

1. Has your child had Chicken Pox? _____ Year _____

2. Are there any hearing or visual defects for which the school could help compensate by seating or other action? YES () NO ()

If yes, explain: _____

3. Is there a defect which limits the student's participation in:

Classroom activities? YES () NO () Competitive athletics? YES () NO ()

Physical education program? YES () NO ()

If so, explain: _____

4. Is there a mental, emotional or physical condition for which the child should receive periodic care?

YES () NO () If so, explain: _____

At what intervals should the child be rechecked? _____

5. If there are any restrictions of normal activities recommended by your physician, we would like to receive a statement from him/her that can be included with this record.

Parent Signature

Date