

Student Number _____
Enrollment Date _____

**NEBRASKA CITY PUBLIC SCHOOLS
NEW STUDENT ENROLLMENT**

Student Legal Name _____ Grade _____ Gender M F
Last Name First Name MI

Preferred Name _____ Graduation Year: 20____ DOB ____/____/____

Enrolled From _____ Place of Birth _____
(Previous School Name and City, State) (City, State)

Attended school at NCPS before? Yes / No If Yes, what grade/year last attended: _____

Primary Language Spoken in Home _____

ETHNICITY: Is this student of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race? No, not Hispanic/Latino Yes, Hispanic/Latino

RACE (Check one or more): Asian Native Hawaiian/Pacific Islander White
 American Indian/Alaska Native (North, Central, & South America) Black/African American

Primary Phone (____) _____ - _____ Student Cell Phone (____) _____ - _____

Physical (Home) Address _____
Street City, State ZIP Code

Mailing Address _____
Street/P.O. Box City, State ZIP Code

Second Mailing (to receive school information) Address _____
Relationship Name Street/P.O. Box City, State ZIP Code

Parent's E-mail Address _____
Father/Stepfather/Guardian email Mother/Stepmother/Guardian email

Father's Name _____ Cell Phone (____) _____ - _____
Last Name First Name

Place of Employment _____ Work Phone (____) _____ - _____

Mother's Name _____ Cell Phone (____) _____ - _____
Last Name First Name

Place of Employment _____ Work Phone (____) _____ - _____

Legal Parents are: Married Separated* Divorced* Single/Never Married*
* Please provide legal custody documents – see reverse side

StepFather/Guardian's Name _____ Cell Phone (____) _____ - _____
Last Name First Name

Place of Employment _____ Work Phone (____) _____ - _____

StepMother/Guardian's Name _____ Cell Phone (____) _____ - _____
Last Name First Name

Place of Employment _____ Work Phone (____) _____ - _____

Child is presently living with (circle): Mother Father Stepmother Stepfather Grandmother Grandfather Guardian

Please check all that pertain to this student:

Special Education/IEP _____ Speech Language _____ 504 Plan _____ Band _____
English Language Learner _____ High Ability Learner _____ SAT _____ Other _____

Please list all other children living in your home:

Name	DOB	Grade	Biological Sibling	Half Sibling	Step Sibling	Non-Relative
_____	____/____/____	_____	_____	_____	_____	_____
_____	____/____/____	_____	_____	_____	_____	_____
_____	____/____/____	_____	_____	_____	_____	_____

List emergency contacts **OTHER THAN PARENTS** (contacts who live in town, please!):

Emergency Contact 1 _____ Phone (____) _____ - _____
Name Relationship to student Type (circle): cell / work / home

Emergency Contact 2 _____ Phone (____) _____ - _____
Name Relationship to student Type (circle): cell / work / home

Emergency Contact 3 _____ Phone (____) _____ - _____
Name Relationship to student Type (circle): cell / work / home

Does anyone other than the natural mother/father have **legal guardianship** or **legal custody*** papers on this student? Yes or No

If 'yes', please give name and relationship to the student _____

***Copies of legal papers assigning guardianship must be on file at the school before the school can release information to anyone other than the parents.**

Has a **legal restraint**** been placed on anyone relating to the child? Yes or No

****Copies of the legal documentation detailing any restraints must be on file at the school before the school can legally follow any restraining order.**

Is the student's parent or guardian a member of the Armed Forces on active duty or on full-time National Guard duty? Yes or No

Medical Information

Please check all that apply with a **date or age** of student:

Allergies _____ Asthma _____ If either is checked, fill out Asthma/Allergy Action Plan form (yellow)

If student has an allergy, please list type of allergy _____

Diabetes _____ Mononucleosis _____ Bronchitis _____ Tonsillitis _____

Seizures _____ Draining Ear _____ Ear Infections _____ Eczema _____

Bronchitis _____ Heart Problem _____

Stomach Problem _____ Dietary Restrictions (medical or religious) _____

Behavioral/Emotional Concerns _____ Wetting/Soiling Pants _____

Does your child take any medication on a regular basis? Yes or No

If 'yes', please list name of medication, dosage amount and dosage time:

Will your child need to take medicine at school? Yes or No If yes, complete Medication form.

Please list any injuries, surgeries or permanent disabilities with a date or age of student: _____

Does this child have a health condition now under treatment? _____

Date of Last Physical _____ Date of Last Dental Exam _____ Date of Last Eye

Exam _____ Parent/Guardian Signature _____

Date

