



GREENVILLE
CENTRAL SCHOOL DISTRICT

Greenville, NY 12083
(518) 966-5070 ext. 305
Fax: (518) 966-6033

For Office Use Only					
Enroll Date: _____	Proofs of Residence _____				
Immunization: Y or N	Birth Certificate: Y or N	Other: _____			
Student ID#: _____					
Home School	ES	MS	HS	Restrictions: _____	

STUDENT ENROLLMENT FORM

The information on this form is very important. **PLEASE PRINT CLEARLY.**

Student Name: _____ M or F Grade Entering: _____
(Last First Middle initial) (Circle one)

Date of Birth: _____ Birthplace: _____

U.S. Citizen Yes or No Date entered USA, if born in foreign country: _____

County of Residence: _____

Ethnic category (choose all that apply): White American Indian/Alaskan Native Pacific Islander
 Asian Black (Non-Hispanic) Hispanic

Physical Address: _____
(Number) (Street) (Town) (Zip Code)

Transportation information:
Exact location of residence with a brief description including color and type of house.

Please remember that transportation will be based on the information you have provided, so please be specific. If your child requires daycare transportation please fill out the Elementary School Sitter Transportation Request form.

Mailing Address (if different and/or P.O. Box): _____

Previous School District Attended: _____

Previous Home Address: _____

Has your child ever been retained? Yes or No If Yes, What Grade? _____
Has your child ever attended Greenville Central School? Yes or No If Yes, When? _____ Grade _____

Name(s) of Brothers and Sisters (Attach additional sheet if needed.)

Name (Last, First, Middle)	M or F	Birth date (m/d/yy)	Birthplace	Grade	School
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are there any restricted releases for this child? (Documentation required. Please attach.) _____

If your child has received special education services or accommodation through an Individualized Education Program (IEP) or a Section 504, please sign consent for the release of special education records so that special education services can begin as soon as possible.

Consent for release of special education records signed? Yes No

Parent /Guardian 1 Name: Dr./Mr./Ms. _____
(Last First Middle initial)

Relationship to student: _____

Address (if different from student) _____

Lives with Student Has Custody of Student Should Receive Student Mailings

Telephones:

Home: _____ Work: _____ Cell: _____

E-mail Address: _____

Employer's Name: _____

Work Address: _____

Parent/Guardian 2 Name: Dr./Mr./Ms. _____
(Last First Middle initial)

Relationship to student: _____

Address (if different from student): _____

Lives with Student Has Custody of Student Should Receive Student Mailings

Telephones:

Home: _____ Work: _____ Cell: _____

E-mail Address: _____

Employer's Name: _____

Work Address: _____

If parent/guardian cannot be reached

Emergency Contact 1 Name: Dr./Mr./Ms. _____
(Last name, First name, Middle initial)

Relationship to student: _____

Address (if different from student): _____

Employer's Name and Address: _____

Telephones

Home: _____ Work: _____ Cell: _____

Emergency Contact 2 Name: Dr./Mr./Ms. _____
(Last name, First name, Middle initial)

Relationship to student: _____

Address (if different from student): _____

Employer's Name and Address: _____

Telephones

Home: _____ Work: _____ Cell: _____



Ear Health History
For Students Entering Grades K-3
Form to be completed by Parent or Guardian

Child's Name: _____

Parent/Guardian: _____ Child's Age: _____

Please help us better understand your child by answering the following questions:

1. Does your child have normal hearing (when ears are clean and healthy)? _____

2. Did your child ever have ear infections? If so, how many total? _____

Between birth to 1 year old _____	3 to 4 years old _____
1 to 2 years old _____	4 to 5 years old _____
2 to 3 years old _____	5+ years old _____

How long did the ear infections last? _____
How often did they re-occur? _____

3. Has your child had myringotomies and PE tubes inserted? _____
if so, how many times and at what ages? _____

4. Has your child ever been seen by an ear, nose, and throat doctor? _____

5. Has your child ever been seen by an audiologist for hearing testing? _____

6. Has your child received speech/language therapy? _____

If so, at what ages and for how long? _____

Therapy was for: _____ articulation _____
language or other _____ (please explain) _____

7. Has your child received amplification during periods of not hearing? _____



HEALTH HISTORY FOR NEW ENTRANTS

This form should be completed and signed by the parent or guardian

Name: _____ Date of birth: _____

Family Physician: _____ Phone: _____

Last visit to M.D. (date, reason): _____ Next M.D. visit (date, reason): _____

Preferred Hospital: _____ Dentist: _____ Last Visit to Dentist: _____

Pregnancy history (gestational diabetes, bed rest, medication needs)

Labor and Birth History (emergency delivery, premature labor, birth trauma, delayed discharge from hospital):

Gestation: ___ Full term ___ Premature Delivery: ___ Normal ___ Cesarean Birth Weight: _____

Growth and Development: Walked at age: _____ Spoke first word at age: _____ Spoke sentences at age: _____

Health History

Serious illness: _____

Serious injury: _____

Surgery: _____

Check if your child has, or has had, any of the following and provide date when appropriate:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Bee Stings | <input type="checkbox"/> History of PE Tubes | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Food | <input type="checkbox"/> Eye Conditions | <input type="checkbox"/> Rheumatic Disease |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rubella Disease |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Fainting | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> German Measles | <input type="checkbox"/> Speech Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> TB |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chest X-ray |
| <input type="checkbox"/> Cold & Sore Throats | <input type="checkbox"/> Hypotonia | <input type="checkbox"/> Tonsil Problems |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Urinary Reflux |
| <input type="checkbox"/> With Fever | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Without Fever | <input type="checkbox"/> Leukemia | Last Vision Exam: |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Measles | Vision Specialist: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis | Glasses Worn: YES NO |
| | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough |
| | <input type="checkbox"/> Orthopedic Conditions | |

Current Health Status (Please state if your child is, or has been, under treatment, or taking medication:

Health conditions under treatment: _____

Medical provider(s) providing treatment: _____

Medication(s) prescribed: _____

Will medications need to be given while your child is at school?
 Yes* Not known at this time *Prescription required by Physician

Are there any physical restrictions or limitations for physical education or other activities at school?
 Yes No *If restrictions or limitations, Physicians written documentation is required

Has your child ever received, or is currently receiving, the following services:
 OT PT Speech Other

Parent/Guardian signature

Date



GREENVILLE
CENTRAL SCHOOL DISTRICT

Greenville, NY 12083
(518) 966-5070 ext. 305
Fax: (518) 966-6033

Date Mailed or Faxed: _____

AUTHORIZATION FOR THE RELEASE OR TRANSFER OF INFORMATION

Student Name: _____

Name and address of school last attended:

School: _____

Address: _____

Phone and/or Fax: _____

The above student has enrolled in our school district. Please forward all school records including health, psychological, discipline including records of suspension, academic and other data. Thank you for your assistance.

MAIL OR FAX TO:

Greenville Central School District
Office of the Registrar
Attn: Lynette Terrell
P.O. Box 129, Rt. 81
Greenville, N.Y. 12083
Fax: (518) 966-6033

Signature of Parent or Guardian

Date