

Independent School District #181
Brainerd, MN 56401

ELEMENTARY ENROLLMENT FORM

For Office Use Only	
Copy of Birth Certificate	_____
Copy of Immunization Record	_____
MARSS #	_____
Resident District	_____
Date of Records Request	_____
Date Records Received	_____

Today's Date _____

Student's Legal Name _____ Gender: Male Female
(Last) (First) (Middle)

Date of Birth _____ Age _____ Grade _____ Graduation Year _____

City and State of Birth _____

Is student Hispanic/Latino? Yes No

Race: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White

Student's First Day of School will be _____
(month/day/year)

Based on District Guidelines, do you require bussing? Yes No

School Last Attended _____
(Name) (Phone Number)

(Address) (City) (State, Zip)

Has student ever previously attended a school in Brainerd? Yes No

Student Lives With: Both Parents Father only Mother only Other, relationship _____
 Father and _____ Mother and _____
(relationship) (relationship)

Student's Address _____ Home Telephone # _____
_____ Primary Home Language _____

Father/Guardian Name _____ email address _____
Address _____ City, State, Zip _____
Employed at _____ Work # _____ Cell # _____

Mother/Guardian Name _____ email address _____
Address _____ City, State, Zip _____
Employed at _____ Work # _____ Cell # _____

Siblings _____ School _____ Gender: M F Birthdate _____
_____ School _____ Gender: M F Birthdate _____
_____ School _____ Gender: M F Birthdate _____
_____ School _____ Gender: M F Birthdate _____

STUDENT HEALTH INFORMATION

Does your child have any medical concerns that the school should be aware of? Yes No
If yes, what? _____

Is your child taking any medications? Yes No
If yes, what medications? _____

Medications may be brought to school for administration only with a written consent from a parent. All medication administered in school will require a written order by a licensed healthcare provider. Medication to be administered must be brought to school in the container labeled by the pharmacy or physician.

Is your child receiving extra assistance during the school day? Yes No
(Example: Title I, Special Education)
If yes, in what areas? _____

Does your child have a current Individual Education Plan (IEP)? Yes No
If yes, what services were provided? _____

EMERGENCY CONTACT – other than those living with student

(1) _____
Name Relationship Phone Other Phone
Address _____ City, State, Zip _____

(2) _____
Name Relationship Phone Other Phone
Address _____ City, State, Zip _____

SECOND FAMILY or NON CUSTODIAL INFORMATION

Complete information below if applicable to family situation and is not listed on page 1.

The parent(s) / guardian(s) listed below shall have access to the student's records unless court documentation is provided.

Father/Stepfather/Guardian Name _____

Address _____ Cell phone # _____

Employed at _____ Telephone # _____

Work #, ext. _____

Mother/Stepmother/Guardian Name _____

Address _____ Cell phone # _____

Employed at _____ Telephone # _____

Work #, ext. _____

This information will help us plan the **Kindergarten** school year. If your plans for kindergarten change, or if you have a change of address, please contact the ISD #181 Main Office at 454-6900 or call the Early Childhood Center at 454-5430.

- 1) My Child is eligible to start Kindergarten in _____.
____ I plan to have my child start Kindergarten then.
____ I plan to have my child remain at home another year.
____ I am undecided at this time

- 2) My child will attend:
____ Brainerd Public Schools
____ Lake Region Christian School
____ St. Francis Parochial School
____ Other _____

- 3) ____ We may or will be moving out of the area.

Parent's Signature _____