Rochester Public Schools

Office of Registration and Records | 615 7th Street SW, Rochester, MN 55902

Today's Date	ESL NCC	LANG	LLA	Enrollment Date	Student ID	Res Dist	Grid #

Student's (Legal) Last Name **(Legal) First Name** **(Legal) Middle Name**

Gender M ☐ F ☐

Date of Birth (month/day/year)

Has this student or any siblings ever attended any Rochester School? Yes ☐ No ☐ Minnesota School? Yes ☐ No ☐

Student Address **Lot/Apt#** **City** **State** **Zip**

Phone (Circle Type): Home Cell

Transportation Services
If eligible will child use transportation services?
Yes ☒ No ☐

Student lives with: (Check all that apply) ☐Both Parents ☐Mother ☐Father ☐Step-Parent** ☐ Foster Parent** ☐ Guardian** ☐Other** ☐Alone

*****Additional guardians can be added on back of form.**

Guardian #1 Relationship To Student _____ Gender: M ☐ F ☐

Full Name _____
Last First Middle

Address (if different) _____ Phone _____

City _____ State _____ Zip _____

Employer: _____ **Work Phone:** _____

Primary Email: _____

Guardian #2 Relationship To Student _____ Gender: M ☐ F ☐

Full Name _____
Last First Middle

Address (if different) _____ Phone _____

City _____ State _____ Zip _____

Employer: _____ **Work Phone:** _____

Primary Email: _____

STUDENT SUPPORT SERVICES INFORMATION:
*Complete additional questions on reverse side.
Does your child have an IEP? If yes, please check student's primary disability.

- ☐Autism Spectrum Disorders
- ☐Deaf and Hard of Hearing
- ☐Developmental Cognitive Disability (Mild)
- ☐Developmental Cognitive Disability (Severe)
- ☐Emotional-Behavioral Disorder
- ☐Other Health Disorder
- ☐Physical Impairment
- ☐Specific Learning Disability
- ☐Visual Impairment
- ☐Traumatic Brain Injury
- ☐Speech Language Impairment

Does your child require special transportation? (Check) Wheelchair ☐ Seizures ☐ Car-Seat ☐ Other ☐

Does your child receive special accommodations at a school for a disability (504 Plan)? Yes ☒ No ☐
(If yes, please provide a copy for our records)

HOME LANGUAGE*
1st language learned by student: _____
Language normally used by student at home: _____
Language normally used by parents at home: _____
Does parent/guardian require an interpreter? Yes ☐ No ☐

NEW U.S. RESIDENT INFORMATION*
Date student entered the U.S. _____
From which country _____ Date started school _____
Refugee ☐ Immigrant ☐
Have you moved to this school district within the last 3 years for temporary or seasonal agricultural or fishing work (migrant)?
Yes ☒ No ☐

Ethnic/Race
(Check One)

- ☐Am. Indian
- ☐Asian
- ☐Hispanic
- ☐Black
- ☐White

Please list, in order of birth, all children in this family (INCLUDING STUDENT LISTED ABOVE)

	Last Name	First	Middle	Gender	DOB	Birth City/State
1.						
2.						
3.						
4.						
5.						
6.						

(Office Use Only)
School Year _____ - _____

Name	School Grade

REQUEST FOR HEALTH AND EDUCATIONAL RECORDS
Last date of attendance at previous school: _____
School most recently attended by student:

School Phone Number _____ County _____

School Name _____

Address _____

City _____ State _____ Zip _____

Parent/Guardian Signature

Initial of Office Personnel _____

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TENNESSEN NOTICE

All Minnesota school districts are part of a state-wide computer reporting system which uses personally-identifiable information to record information about your child. This information is, in turn, provided to the Minnesota education department. This department is required by law to collect and store information about each pupil, each staff member, and each educational program. **Therefore, we ask that you, the parent, provide your child's personally-identifiable information below and marked with * on the front side of this form. The education department uses this information to determine how much money your school district receives from the state and federal government. This information is also used to judge the quality of the state's educational programs, to improve instruction, to follow trends in student enrollment, and to track student participation in various programs.

Your child's school district will share this information with the education department. The education department will share the information with the Department of Human Services to allocate additional funding and improve instruction. As a parent, you do not have to provide the personally-identifiable information for your child. However, if you choose not to provide the information, services may not be provided from the beginning of the child's enrollment (i.e., special education or ESL service).

SPECIAL EDUCATION QUESTIONS:

1. At your previous school, how much time did your child spend each day in a special education room?
   ☐ 1 hour or less ☐ Less than half a day ☐ Most of the school day

2. List the name and phone number of the last school special education teacher: _____

3. If you have a copy of the current IEP and current Evaluation/Assessment Report, please provide those to our District as soon as possible.

Ethnicity/Race

In accordance with state and federal regulations, we are required to collect and report student ethnicity and race using the two part question below. Please complete this form and submit with registration materials.

Today's Date:

Student Name (last name, first name):

Date of Birth:

Part A. **Is this student Hispanic/Latino?** (Choose only one)

☐**No, not Hispanic/Latino**

☐**Yes**, **Hispanic/Latino** (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.)

The above part of the question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate what you consider your student's race to be.

Part B. **What is the student's race?** (choose one or more)

☐**American Indian or Alaska Native** (A person having origins in any of the original peoples of North or South America including Central America, and who maintains a tribal affiliation or community attachment.)

☐**Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.)

☐**Black or African American** (A person having origins in any of the black racial groups of Africa.)

☐**Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.)

☐**White** (A person having origins in any of the original peoples of Europe, the Middle East or North Africa.)

Residency Information*

Is the student's current address a temporary living arrangement? ☐ Yes ☐ No If yes, continue:

Is this temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

Does the student lack a fixed, regular, adequate nighttime residence? ☐ Yes ☐ No

*Residency information is used for the purpose of determining eligibility for services under federal laws for providing education to students in temporary living situations.

PRINT FORM

RESET FORM

Rochester Public Schools

SCHOOL HEALTH INFORMATION FORM

STUDENT INFORMATION

Name DOB / / Gender ☐M ☐F

School Grade Parent/Guardian Name

Phone # Phone # Email

HEALTH HISTORY

Check all conditions your child currently has or has been treated for in the past

	CONDITION	EXPLAIN
☐	Diabetes	
☐	Seizures	
☐	Allergies	
☐	Asthma	
☐	Lung/Respiratory Disease	
☐	Heart/Cardiovascular Conditions	
☐	Head Injury/Concussion	
☐	Behavioral or Emotional Difficulties	
☐	Neurological Disorders	
☐	Attention Disorders (ADD,ADHD)	
☐	Mental Health Conditions (e.g., anxiety, depression)	
☐	Fainting Spells and Dizziness	
☐	Kidney/Bladder Conditions	
☐	Ear/Eyes/Nose/Sinus Problems	
☐	Muscle or Bone Conditions	
☐	Abdominal/Stomach/Digestive Problems	
☐	Migraines or Severe Headaches	
☐	Food Restrictions/Special Diet	
☐	Skin Conditions	
☐	Mobility Problems or Activity Restrictions	
☐	Learning Problems	
☐	VISION CONCERNS	Glasses/Contacts ☐Yes ☐No For: Last professional eye exam / / Results:
☐	HEARING CONCERNS	Hearing Device ☐Yes ☐No Type: ☐Right ☐Left ☐Both ears
☐	**List any other medical conditions:**	

MEDICATIONS

List all prescription, over-the-counter, and medications taken as needed (e.g., EpiPen, inhalers, pain relievers)

Medication	Dose	Frequency	Reason

Would you like to schedule a conference with the licensed school nurse to discuss a particular health concern? ☐Yes ☐No

Indicate your concern(s):

The information you provide will only be shared with school staff who require access to this information to meet your child's health and safety needs while at school. Not providing complete and accurate information may result in an incomplete health and safety plan for your child.

Parent/Guardian signature

Date / /

FOR OFFICE USE ONLY: charted: _____(initial)