Office Use Only:

Student I.D. No._____
SSID No._____

Pacific Elementary School District
New Enrollment Form
(To be completed by the parent or guardian)

Anticipated Start Date in Pacific School District:_____

Male ☐
Female ☐
Non-Binary ☐

Student's LEGAL Name:_____ Date of Birth:_____
(from birth certificate) Last Name First Name Middle Name Mo./Day/Year

_____|_____| (_____)_____| (_____)_____
Parent 1/Guardian's First Name Last Name Home Phone Cell/Work Phone

_____|_____|(_____)_____| (_____)_____
Parent 2/Guardian's First Name Last Name Home Phone Cell/Work Phone

_____
Parent EMAIL Addresses

_____
Residence Address City State Zip

Last School Attended:_____Last Day of Attendance_____
Name of School City/State

Student's Birthplace: _____ If not born in the U.S., what month/year did your child enter U.S.? _____/_____
City/State/Country Mo./Year

What month and year did your child first enroll in a *U.S.* school? _____/_____
Mo. / Year

Must answer both questions

ETHNICITY: *Mark the ethnicity with which the student most closely identifies: Please check one:*

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

☐ Not Hispanic or Latino

WHAT IS YOUR CHILD'S RACE (Please check up to five racial categories) 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 race to be.

☐ **American Indian or Alaskan Native (100)** (Person having origins in any of the original people of North and South America (including Central America)

☐ Chinese (201)
☐ Japanese (202)
☐ Korean (203)
☐ Vietnamese (204)
☐ Asian Indian (205)
☐ Laotian (206)
☐ Cambodian (207)
☐ Hmong (208)
☐ Other Asian (299)
☐ Hawaiian (301)
☐ Guamanian (302)
☐ Samoan (303)
☐ Tahitian (304)
☐ Other Pacific Islander (399)
☐ African American or Black (600)
☐ White (700) (Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)

HOME LANGUAGE SURVEY

Which language did your son/daughter learn when he/she first began to talk?_____

What language does your son/daughter most frequently use at home?_____

What language do you use most frequently to speak to your son/daughter? _____

Name the language most often spoken by the adults at home:_____

PARENT EDUCATION LEVEL: Check the response that describes the highest education level of parent/guardian(s):

☐ Not a high school graduate
☐ High school graduate
☐ Some college (includes AA degree)
☐ College graduate
☐ Graduate school/post graduate training

What special services has your child received OR been recommended to receive? *(Please check all boxes that apply)*

Special Education: ☐ Resource (RSP) ☐ Special Day Class (SDC) ☐ Speech/Language ☐ 504 Accommodation Plan
Other: ☐ Gifted (GATE) ☐ Remedial Math ☐ Remedial Reading ☐ Counseling ☐ English Language Development ☐ Medical Health Plan

Has the student been expelled or is the student in the process of being expelled from any school? Yes ☐ No ☐

If yes: Name of school:_____Location:_____ Date:_____

RESIDENCE – where is your child/family currently living? (Please check appropriate box)

☐ In a single family permanent residence (house, apartment, condo, mobile home)
☐ Doubled-up (sharing housing with other families/individuals due to economic hardship, loss, or other reasons)
☐ In a sheltered or transitional housing program
☐ In a motel/hotel
☐ Unsheltered (car/campsite)
☐ Other_____

OTHER CHILDREN IN THE FAMILY:

First and Last Name	Relationship	Lives at Home	School	Age	Grade
		Yes ☐ No ☐			
		Yes ☐ No ☐			
		Yes ☐ No ☐			
		Yes ☐ No ☐			

OTHER ADULT(s) IN THE HOME:

Name	Relationship	Name	Relationship

HEALTH HISTORY *(Check all that apply)*

Diagnosed ADD or ADHD..... ☐
Asthma..... ☐
Bladder Problems..... ☐
Bleeding Disorder..... ☐
Color Vision Deficiency..... ☐
Diabetes..... ☐
Eczema/Skin Trouble..... ☐
History of Ear Problem..... ☐
Heart Problem..... ☐
Head Injury..... ☐
History of Fractures..... ☐
History of Hospitalization..... ☐
History of Surgery..... ☐
Known Hearing Loss..... ☐
Known Vision Loss..... ☐
Physical Limitations..... ☐
Wears Contact Lens..... ☐
Wears Glasses..... ☐

Epilepsy..... ☐
Eye Injury..... ☐
Hypoglycemia..... ☐
Frequent Nosebleeds..... ☐
Scoliosis..... ☐
Seizure Disorder..... ☐
Chicken Pox..... ☐

Describe_____
Describe_____
Describe_____
Describe_____
Describe_____
Describe_____
Right ☐ Left ☐
Right ☐ Left ☐
Describe_____

For close work ☐ For distance only ☐ At all times ☐

Other or further details of above _____

_____

ALLERGIES *(Check all that apply)* None: ☐

Animals ☐ Drugs ☐
Insects ☐ Food ☐
Bee Stings ☐ Plants ☐
Other ☐

List specific item(s) student is allergic to:_____

Describe allergic reaction and/or treatment:_____

Explain:_____

CURRENT MEDICATION(S) No ☐ Yes ☐ Epi-Pen ☐ If medication is needed at school, permission must be given to the office by parent and doctor. Please list below AND submit a completed SCHOOL MEDICATION FORM (available on the school website):

Name of Medication(s)	Dosage	Time Taken	Purpose

EMERGENCY MEDICAL AUTHORIZATION

I am/we are the parent/guardian of the above named student. In case I am/we are unable to be reached during any emergency, I/we hereby authorize a representative of the school, pursuant to the provisions of Family Code Section 6910, to act as any agent to consent to the giving of any and all medical, dental, hospital or surgical care to the above named student. . Yes ☐ No ☐

I/We have reviewed this two page document and to the best of my/our knowledge, the information contained herein is true and complete. The undersigned declares under penalty of perjury that they are the parents or legal guardians of the above-named student and grant the above authorizations.

Date:_____ **Signature of Parent/Guardian:**_____

Revised:1/29/19