

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

Office Use Only:
Student I.D. No. _____
SSID No. _____

Anticipated Start Date in Pacific School District: \_\_\_\_\_

Student's LEGAL Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male   
(from birth certificate) Last Name First Name Middle Name Mo./Day/Year Female   
 Non-Binary

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

**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.**

<input type="checkbox"/> American Indian or Alaskan Native (100) <small>(Person having origins in any of the original people of North and South America (including Central America)</small>	<input type="checkbox"/> Korean (203)	<input type="checkbox"/> Hawaiian (301)	<input type="checkbox"/> African American or Black (600)
<input type="checkbox"/> Chinese (201)	<input type="checkbox"/> Vietnamese (204)	<input type="checkbox"/> Guamanian (302)	<input type="checkbox"/> White (700) <small>(Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)</small>
<input type="checkbox"/> Japanese (202)	<input type="checkbox"/> Asian Indian (205)	<input type="checkbox"/> Samoan (303)	
	<input type="checkbox"/> Laotian (206)	<input type="checkbox"/> Tahitian (304)	
	<input type="checkbox"/> Cambodian (207)	<input type="checkbox"/> Other Pacific Islander (399)	
	<input type="checkbox"/> Hmong (208)		
	<input type="checkbox"/> Other Asian (299)		

**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       Some college (includes AA degree)       Graduate school/post graduate training

High school graduate       College graduate

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)       In a motel/hotel

Doubled-up (sharing housing with other families/individuals due to economic hardship, loss, or other reasons)       Unsheltered (car/campsite)

In a sheltered or transitional housing program       Other \_\_\_\_\_

Must answer both questions

**OTHER CHILDREN IN THE FAMILY:**

First and Last Name	Relationship	Lives at Home	School	Age	Grade
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____	_____

**OTHER ADULT(S) IN THE HOME:**

Name	Relationship	Name	Relationship
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**HEALTH HISTORY (Check all that apply)**

- |  |  |
|--|--|
| Diagnosed ADD or ADHD..... <input type="checkbox"/>      | Epilepsy..... <input type="checkbox"/>   |
| Asthma..... <input type="checkbox"/>                     | Eye Injury..... <input type="checkbox"/>   |
| Bladder Problems..... <input type="checkbox"/>           | Hypoglycemia..... <input type="checkbox"/>   |
| Bleeding Disorder..... <input type="checkbox"/>          | Frequent Nosebleeds..... <input type="checkbox"/>  |
| Color Vision Deficiency..... <input type="checkbox"/>    | Scoliosis..... <input type="checkbox"/>  |
| Diabetes..... <input type="checkbox"/>                   | Seizure Disorder..... <input type="checkbox"/>   |
| Eczema/Skin Trouble..... <input type="checkbox"/>        | Chicken Pox..... <input type="checkbox"/>  |
| History of Ear Problem..... <input type="checkbox"/>     | Describe _____   |
| Heart Problem..... <input type="checkbox"/>              | Describe _____   |
| Head Injury..... <input type="checkbox"/>                | Describe _____   |
| History of Fractures..... <input type="checkbox"/>       | Describe _____   |
| History of Hospitalization..... <input type="checkbox"/> | Describe _____   |
| History of Surgery..... <input type="checkbox"/>         | Describe _____   |
| Known Hearing Loss..... <input type="checkbox"/>         | Right <input type="checkbox"/> Left <input type="checkbox"/>   |
| Known Vision Loss..... <input type="checkbox"/>          | Right <input type="checkbox"/> Left <input type="checkbox"/>   |
| Physical Limitations..... <input type="checkbox"/>       | Describe _____   |
| Wears Contact Lens..... <input type="checkbox"/>         |  |
| Wears Glasses..... <input type="checkbox"/>              | For close work <input type="checkbox"/> For distance only <input type="checkbox"/> At all times <input type="checkbox"/> |

Other or further details of above \_\_\_\_\_

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

- |                                     |                                 |   |
|-------------------------------------|---------------------------------|---|
| Animals <input type="checkbox"/>    | Drugs <input type="checkbox"/>  | List specific item(s) student is allergic to: _____ |
| Insects <input type="checkbox"/>    | Food <input type="checkbox"/>   | Describe allergic reaction and/or treatment: _____  |
| Bee Stings <input type="checkbox"/> | Plants <input type="checkbox"/> |   |
|                                     | Other <input type="checkbox"/>  |   |
- 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: \_\_\_\_\_