



# STUDENT ENROLLMENT FORM

\_\_\_\_\_ (legal last name) \_\_\_\_\_ (legal first name) \_\_\_\_\_ (nickname) \_\_\_\_\_ (middle name)

Student lives with (Please circle one) both parents same household mother father 50/50 other \_\_\_\_\_

Has this person lived in Neenah previously? \_\_\_\_\_ Has this person been expelled (or is pending expulsion) in another district? Y or N  
If so, please list the district \_\_\_\_\_

Gender (Please circle one): M or F Birth Date \_\_\_/\_\_\_/\_\_\_

**For Office Use Only**  
Birth Certificate   
Parent Statement   
Initials: \_\_\_\_\_

Is this student Hispanic or Latino? \_\_\_ No, not Hispanic or Latino \_\_\_ Yes, Hispanic or Latino

Race (circle all that apply; you must choose at least one):  
American Indian or Alaska Native Asian Black Native Hawaiian or Other Pacific Islander White

**What is this student's Ethnicity (write one)** \_\_\_\_\_

Primary languages spoken \_\_\_\_\_

What language did your child speak when he/she first began to talk? \_\_\_\_\_ What languages does your child speak at home? \_\_\_\_\_ What languages do you or other parent/guardians use when speaking to this student? \_\_\_\_\_

Birth City \_\_\_\_\_ Birth County \_\_\_\_\_ Birth State \_\_\_\_\_

This person is enrolling at (School) \_\_\_\_\_ Grade \_\_\_\_\_ Start Date \_\_\_\_\_

I wish to apply for enrollment at Alliance Charter School YES NO (circle one)

Deadline for applying to Alliance Charter Elementary School is February 26, 2010

Transferring from (School) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**EMERGENCY CONTACT: (if parent/guardian cannot be reached)**

\_\_\_\_\_ (last name) \_\_\_\_\_ (first name) \_\_\_\_\_ (middle name)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Relationship to student \_\_\_\_\_

Has this person received special program/special education services? \_\_\_\_\_ If yes, please list the type of disability (for example: SLD, ED, CDS, etc.) \_\_\_\_\_

Please list any medical conditions (For example: ADD/ADHD, Allergies, Asthma, Diabetes, Mental Health, Cardiac, Neurological, Seizure, Orthopedic, Vision/Hearing Conditions, Activity Restrictions) \_\_\_\_\_

Are medications to be taken at school? Y or N If so, please list. \_\_\_\_\_

Immunizations received last year \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_

I verify that all information is complete and accurate \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of parent/guardian)