WEST LAFAYETTE COMMUNITY SCHOOL CORPORATION
Cumberland Elementary School
West Lafayette, IN 47906

Mark Preference 1, 2 and 3

_____ Reg. No.
_____ Resident
_____ Tuition

___ All Day
___ Half Day AM
___ Half Day PM

ENROLLMENT FORM

STUDENT INFORMATION

STN: _____

DATE: _____

Legal Name of Student _____
(Last) (First) (Middle)

Name Student Wishes to Be Called: _____ Grade Enrolling In: _____

Sex: M ____ F ____ Birthdate: _____ Place of Birth _____ Phone: _____
(City, State/Country) (home)

Student's Home Address: _____
(Street) (City) (Zip)

Previous School Attended: _____

Address: _____ City/State _____ Zip _____

Last Day at Previous School: _____

First Language Spoken by Student: _____ **Language Spoken Most Often** _____

Language Most Often Spoken at Home: _____ **Does Student Speak English?** _____

Is student currently in Glass Preschool or Special Education: _____ If so, what Classification? _____

FAMILY INFORMATION

With whom is the Child Living: Title (check one)

_____ Mr. and Mrs.
_____ Mrs.
_____ Dr. and Mrs.
_____ Dr. & Dr.
_____ Other _____

_____ Mr.
_____ Ms.
_____ Rev. & Mrs.
_____ Mr. & Dr.

Relationship (check one)

_____ Mother/Father
_____ Mother Only
_____ Father Only
_____ Foster Parents
_____ Other _____

_____ Mother/Stepfather
_____ Father/Stepmother
_____ Guardian(s)

FATHER
Name of Father, Stepfather, Legal Guardian with whom the student lives:

_____
(Last) (First) (Middle)

E-mail: _____

Cell Phone: _____

MOTHER
Name of Mother, Stepmother, Legal Guardian with whom the student lives:

_____
(Last) (First) (Middle)

E-mail _____

Cell Phone: _____

_____
Parent/Guardian Signature

OVER PLEASE

FAMILY INFORMATION – continued

Other Children in the Family:

Name(s)	Birthdate(s)	Living at Home (yes, no)

If parents cannot be reached, whom shall we contact:

Name: _____ **Phone:** _____ **Relationship:** _____

Name: _____ **Phone:** _____ **Relationship:** _____

Name: _____ **Phone:** _____ **Relationship:** _____

If you feel there is any information about your son/daughter that would help us to understand him/her better, please write in the space provided below.

I am aware that falsifying information is a criminal offense in the State of Indiana and that I subject myself to legal action and prosecution if it can be shown that the information given is not true or accurate.

I understand that under these conditions of residence it is my responsibility to provide any additional and reasonable proof to further substantiate that I live at the address on this form. Verification may include unannounced home visits by attendance officers or school officials.

I understand that my children will be withdrawn immediately from WLCSC if it is shown that residence has changed or if information that has been given is inaccurate.

_____ _____

Date Parent/Guardian Signature

OFFICE USE ONLY

Revised 3/26/13

MEDIA CONSENT/DENIAL FORM

WEST LAFAYETTE COMMUNITY SCHOOL CORPORATION

1130 North Salisbury Street West Lafayette, Indiana 47906-2497
765-746-1602 FAX 765-746-1644

Dear Parent/Guardian:

West Lafayette Community is proud to share good news about our students, school programs, and other events in our schools, while protecting learning time and being sensitive to our students' privacy. Therefore, West Lafayette Community School Corporation is giving all parents or legal guardians the opportunity to consent or deny their child in media coverage during the school day.

Possible media coverage includes your child's photo, name, grade, age, writing, and/or quotations to share news about his/her school and the educational program at West Lafayette Community School Corporation during the school year. Media coverage may also include school-sponsored related media such as the school newspaper, school-produced video, parent newsletters, school web pages and local newspapers, television, and/or radio.

Please fill out the form below granting or denying media coverage for his/her school or the West Lafayette Community School Corporation.

Media Consent/Denial

Please complete this form and return it to school. This form is effective for the duration of the student's academic tenure in the West Lafayette Community Schools. Note: While a parent or guardian retains the option of changing consent before the expiration date, such changes may result in financial obligations incurred according to the yearbook-publishing schedule.

Initial only **one** option below:

_____ I **give** permission for my child to be included in ANY corporation OR outside media coverage such as, but not limited to, school newspaper, yearbook, newsletters, TV stations, radio stations, public newspapers, or corporation websites. I know that my decision remains in effect until the expiration of this form or until it is cancelled in writing by, me, the parent or legal guardian.

_____ I **do not** want my child to be included in ANY corporation OR outside agency media coverage such as, by not limited to, school newspaper, yearbook, newsletters, TV stations, radio stations, public newspapers, or corporation websites. I know that my decision remains in effect until the expiration of this form or until it is cancelled in writing by me, the parent or legal guardian.

_____ I **only** want my child to be included in corporation related media coverage such as school newspaper, yearbook, corporation websites, or newsletter.

_____ _____
Student Name (please print) Grade School

_____ _____
Signature of Parent/Guardian Date

2/28/13 Federal law prohibits the identification of special education students by their disability.

WEST LAFAYETTE COMMUNITY SCHOOL CORPORATION
West Lafayette, IN

RACE and ETHNICITY
STUDENT FORM

School: ☐ Cumberland ☐ Happy Hollow ☐ Jr. High ☐ H.S.

Student Name: _____ Grade: _____ Teacher: _____

Race and Ethnicity: (Note: Both Part 1 and Part 2 must be answered)

Part 1: Ethnicity	Is this individual 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.)
Part 2: Race	What is the individual's race? (Choose one or more) ☐ American Indian or Alaska Native: A person having origins in any of the original peoples of North America and maintaining cultural identification through tribal affiliation or community recognition. ☐ 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, North Africa or the Middle East

Parent/Guardian Signature _____ Date _____

Permission
Internet, Media, Director, etc.

PRINT Student's Name _____

PRINT Student's Teacher (K-3) _____

Date _____ **Parent's signature** _____

After reading the below mentioned agreements, indicate your choice **in each area. This form is in effect through your child's elementary school years.** If you wish to change an option, please notify us in writing.

NETWORK Use Agreement (initial one)

____ My child may use the NETWORK to access other networks, such as the Internet as per the internet information I have already received.

____ My child may **NOT** use the NETWORK to access other networks, such as the Internet.

Media Denial/Consent- initial- (print and electronic)

____ I have completed the Media Consent /Denial form for my child and turned it in.

Pesticide (initial one)

____ There is no need to notify me of pesticide use.

____ Notify me in advance of pesticide use in or around the building.

Bus Rules (initial)

____ I understand the bus procedures are on the school's website & will review procedures with my child(ren).

Student Code of Conduct and Handbook (initial)

____ I understand the Code of Conduct and Student Handbook are on the school's website & will review them with my child(ren).

Field Trips (initial)

_____ My child has permission to go on scheduled field trips throughout the school year. I understand that information will be sent home prior to these field trips, advising parents of purpose, location, and any associated fees. If I do not want my child to attend a specific trip, I will advise the teacher at the time information is sent out.

Home Language Survey (HLS)

The purpose of this survey is to determine the primary or home language of the student. The HLS must be given to all students enrolled in the school district. The HLS is administered once, upon initial enrollment in Indiana, and remains in the student's cumulative file.

Please note that the answers to the survey below are student-specific. If a language other than English is recorded for ANY of the survey questions below, the WIDA Placement test will be administered to determine whether or not the student will qualify for additional English language development support.

Please answer the following questions regarding the language spoken by the student:

Name of student_____

1. What is the native language of the **student?** _____
2. What language(s) is spoken most often by the **student?** _____
3. What language(s) is spoken by the **student** in the home? _____

Parent/Guardian Signature: _____ Date:_____

By signing, you certify that responses to the three questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for English language development services, to help them become fluent in English. If entered into the English language development program, your student will be entitled to services as an English learner and will be tested annually to determine their English language proficiency.

For School Use Only:

School personnel who administered and explained the HLS and the placement of a student into an English language development program if a language other than English was indicated:

Staff Name: _____

Date:_____

The Civil Rights Act of 1964, Title IV, Language Minority and Compliance Procedures, requires school districts to determine the language(s) spoken in each student's home in order to identify their specific language needs.

Indiana
DEPARTMENT OF EDUCATION

Dr. Jennifer McCormick
Superintendent of Public Instruction

Working Together for Student Success

The Migrant Education Program (MEP) provides supplemental education and support services to eligible children through national funding. The purpose of the program is to ensure that all migrant students reach the academic standards and graduate with a high school diploma (or complete GED/HSE).

WORK SURVEY

Thank you for answering the following questions. If your child is eligible for the Migrant Education Program, they may receive additional educational support. This information is **strictly confidential.**

Student's Name: _____ Parent's Name: _____

Address: _____ City: _____ Telephone: (___) _____

Date: _____ Parent Signature: _____

1. Within the last **3 years**, have your children moved for any reason? **YES** ____ **NO**____
2. Has anyone in your household moved from one school district to another within the United States, to look for seasonal or temporary work in agriculture? **YES** ____ **NO** ____

   If you answered **NO** to either of these questions, please stop. STOP

If you answered **YES**, please continue.

3. When was the last time you or anyone in your household has moved to look for, or work in an agricultural activity within the United States? Month_____ Year_____
4. Please check any of the agricultural activities listed below that you have looked for or worked in:

____ Plant or harvest vegetables or fruits	____ Canning vegetables or fruits
____ Detassel corn	____ Sod farm
____ Tobacco farm	____ Planting, pruning or cutting trees
____ Poultry and/or egg farm	____ Dairy farm
____ Duck, turkey, chicken, pork or beef processing plant	____ Flora culture/gladiola farm
____ Aquaculture/fish hatcheries	____ Green house or plant nursery

Please list the names of all of the children in the household under 22 years of age.

Child's Name	Date of Birth (D.O.B.)
1.	
2.	
3.	
4.	
5.	

Indiana
DEPARTMENT OF EDUCATION

Dr. Jennifer McCormick
Superintendent of Public Instruction

Working Together for Student Success

**** Confidential****

Military Children in Education — 2017-18 School Year

Purpose: This questionnaire is the result of a Department of Defense (DOD) program supported by Indiana statute 20-19-3-9.4. Confidentially identifying military children and providing data on their attendance and educational outcomes, states can assist schools and districts by providing access to data to help inform policy and program decisions for this unique student population. In addition, DOD will benefit from this data in developing policy for military child education initiatives.

School Name: _____ Student's Grade Level: _____

Student's Full Legal Name: _____
Please print clearly

Please complete the questions that best describe your student's situation. It is possible to answer "yes" to both.

1. Is the above named student connected to an Active Duty military family: _____Yes _____No

Meaning a school-aged child, enrolled or in the process of enrolling in KG-12th grade, is claimed as a dependent by an Active Duty member of the Armed Forces of the United States; or the student and an Active Duty member(s) are of the same household whether or not the active duty member(s) claims the student as a dependent.

"Active Duty" means: full-time duty status in the active uniformed service of the United States.

2. Is the above named student connected to a Guard or Reserve military family: _____Yes _____No

Meaning a school-aged child, enrolled or in the process of enrolling in KG-12th grade, who is claimed as a dependent by a member of the National Guard or Reserve; or the student and National Guard or Reserve member(s) are of the same household whether or not the National Guard or Reserve member(s) claims the student as a dependent.

"National Guard or Reserve" means: members of the Reserve Component as defined in 10 U.S.C. Section 10101. Includes Army National Guard of US, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard of US, Air Force Reserve or Coast Guard Reserve.

_____ _____
Signature Date

ONLY For Students of an ADULT High School (IC 20-24-1-2.3)

Is the above named student an active member of the Armed Forces of the United States _____Yes _____No

OR

Is the above named student a member of the National Guard or Reserve _____Yes _____No

This form shall be handled by schools in a confidential manner in accordance with IDOE Guidance (IC 20-19-3-9.4)

Cumberland Elementary School
WEST LAFAYETTE COMMUNITY SCHOOL CORPORATION
600 CUMBERLAND AVENUE
WEST LAFAYETTE, INDIANA 47906-1522

SCHOOL GROUPS

Various school groups send information and updates to parents throughout the school year. Please fill out the Opt-In Form below. Select the boxes below yes/no on receiving communications from the following groups:

Name: _____

Parent Council: ___Yes ___No

WL Education Foundation: ___Yes ___No

These organizations may contact me by any of the following:

Phone: _____

Email: _____

Mailing Address: _____

Cumberland Elementary School

WEST LAFAYETTE COMMUNITY SCHOOL CORPORATION
600 CUMBERLAND AVENUE
WEST LAFAYETTE, INDIANA 47906-1522

Kim Bowers
Principal

Phone (765) 464-3212
Fax (765) 464-3210

Dear Parent/Guardian,

In accordance with state laws and as a part of our school services, each new student is given a hearing screening. This will be done for your child within a short time after enrollment. You will be notified of the results and arrangements will be made, at that time, for any further evaluation.

In addition, all kindergarten students are given a speech-language screening. You will be notified if any concerns are noted.

The following information is also requested at this time:

Is your child enrolled in special education, with an Individualized Education Program (IEP) from his/her previous school?

_____

(yes/no)

If yes, please check the appropriate eligibility:

_____ Autism Spectrum Disorder
_____ Deaf or hard of hearing
_____ Language
_____ Specific Learning Disability
_____ Other/Not sure
_____ Cognitive Disability
_____ Emotional Disability
_____ Speech
_____ Other health impairment

Child's Name _____

Grade _____ Teacher's Name _____

Dear Parent:

Welcome to West Lafayette Community School Corporation!

Enclosed, please find a consent form for the Indiana State Department of Health's *Children and Hoosiers Immunization Registry Program (CHIRP)*. This consent grants WLCSC permission to register your child's immunizations in CHIRP. Your consent is important as Indiana State Department of Health uses CHIRP to electronically collect state mandated immunization reports.

CHIRP is a statewide confidential immunization database that exists to help ensure that each child has a copy of his/her vaccines available to medical providers and/or schools. Most local physicians access records through CHIRP. This shared database helps ensure records are properly documented and available to reduce possible duplication or missing vaccines. No marketing or solicitation occurs through this database, and the general public cannot login to access records.

If you consent, please complete the enclosed form and return it to your child's school as soon as possible.

If you have questions or concerns, please contact your child's school nurse.

Thank you.

Dr. Rocky Killion
Superintendent of Schools

Dr. Chet Ho
West Lafayette Community School Physician

West Lafayette Community School Corporation
1130 North Salisbury
West Lafayette, IN 47906
765-746-1602

I, _____, as a parent/guardian of _____

give West Lafayette Community School Corporation permission to release the following information concerning my child to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

student name, date of birth, address, phone, race, parent/guardian name and immunization data

I understand that the following information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

_____ _____
Signature Date

_____
Printed Name of Parent or Guardian

_____ (_____)_____
Address Telephone Number

_____ _____
Child's Name Grade Level

_____
School

West Lafayette Community School Corporation
Physical Evaluation
Kindergarten – Sixth Grade
(To be filled out by guardian)

History

Today's Date: _____

Student's Last Name:	Student's First Name:	Middle Initial
Address:	Zip Code	Phone:
Sex: Male ☐ Female ☐	Date of Birth:	Age:	Grade:
Known Allergies:		
Medications currently taking:		

Has your child had **ANY** of the following illnesses? Please list dates when possible.

Condition	Yes	No	Treatments
Asthma?			
Trouble breathing or coughing during or after exercise?			
Racing heart or skipped beats?			
Chest pain during or after exercise?			
Ever passed out or had dizziness during or after exercise?			
Ever been hospitalized?			
Ever had surgery?			
Frequent strep throat?			
Chronic ear infections?			
Ear Tubes?			
Seizures, epilepsy?			
Mononucleosis?			
Chicken pox?			
Pneumonia?			
Frequent Bronchitis?			
Dislocated or fractured bones or joints?			
Ever had a head injury?			
Other concerns:			

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

TURN OVER

Physical Evaluation
Kindergarten – Sixth Grade
(To be filled out by physician)

Patient

Name:			Date of birth:	Age:
Height:	Weight:		BP: ____/_____	Pulse:
Vision:	R: 20/	L: 20/	Corrected: Y N	Pupils (circle): Equal Unequal: R>L Unequal: L>R

System	Normal	Abnormal findings
Heart		
Lungs		
Skin		
Head / Neck		
Eyes		
Ears		
Nose/Throat		
Liver / Spleen		
Kidney		
Musculoskeletal		
Genitalia / Hernia		
Neurological		
Urinalysis		
Hearing		

Immunization Record:

DPT / DTAP	1)	2)	3)	4)	5)	6)
OPV/IPV	1	2	3)	4)	5	
Hepatitis B	1)	2)	3)			
MMR	1)	2)				
Varicella	1)	2)				
Menactra	1)					
HPV	1)	2)	3)			
TB Test	Date:	Result:				
Other:						

Physician's signature: _____ Date: _____

WLCSC Health Information Update
Please return to the School Nurse

School Year _____ Grade _____ Teacher (K-6) _____

NAME _____ M F Birthdate _____

Address _____ Home Phone _____

Mother's Name _____ Work Phone _____

Father's Name _____ Work Phone _____

Mother's Cell _____ Father's Cell _____

Mother's Email _____ Father's Email _____

EMERGENCY CONTACT WHEN PARENTS CANNOT BE LOCATED

1. Name _____ Relationship _____

Home Phone _____ Cell or Work Phone _____

2. Name _____ Relationship _____

Home Phone _____ Cell or Work Phone _____

To assist the nurses in providing excellent care, please complete the following. Please be specific. If your child's health concern is not addressed below, please add it in the "other" category. Thank you!

Physician _____ **Phone** _____

Dentist _____ **Phone** _____

Medications your child takes at home: _____

_____

Asthma

Triggers _____

Medications _____

How often does your child have symptoms of asthma? _____

Seizures

Pre-seizure aura _____

Description of seizure _____

Date of last seizure _____ Medications _____

OVER PLEASE !

Allergies

Food (specify) _____

Drug (specify) _____

Insect (specify) _____

Symptoms of reaction _____

Treatment _____

Diabetes

Insulin Doses _____

Times of Blood Sugar Testing _____

Treatment of High/Low _____

Headaches

Frequency and type _____

Treatment (if meds needed at school, must complete the request form)_____

Gastrointestinal Conditions

Diagnosis _____Symptoms _____

Treatment _____

Learning/Behavioral Conditions (please check all that apply)

ADD ____ ADHD ____ OCD ____ ODD ____ Depression ____ Bipolar ___ LD ____

Other _____

Medications and/or treatment_____

Additional Pertinent Health Conditions: _____

_____

PLEASE CHECK ONE:

_____Information on this form may be shared with school personnel for health/emergency purposes except for information specified as follows: _____

_____ Information on this form may not be shared with school personnel for health/emergency purposes

Parent/Guardian Signature _____ Date _____

Thank you for your help! Please contact your School Nurse with questions.