

Denver Public Schools



School: \_\_\_\_\_

Student ID# \_\_\_\_\_

Registration Form – Student Census/Enrollment Information
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Student Census/Enrollment Information Please print

Student's Full Legal Name: Last First Middle

Grade: Gender: M F Birth date: Month Day Year State/Country of Birth:

Resident Address: Apt/Bldg: City: State: Zip:

Race/Ethnicity

- American Indian or Alaskan Native
Asian or Pacific Islander
Black (Not of Hispanic Origin)
Hispanic
White (Not of Hispanic Origin)

Previous School Information

Has the student attended another DPS School? Yes No School: Grade: School Year:

Last School Attended Outside the Denver Public Schools

School: Grade: School Year: City: State:

List the first time the student was enrolled in any school in the US (including preschool and kindergarten) Month Year Grade (Preschool-12)

List the most recent time the student was enrolled in any school in the US (NOT including preschool and kindergarten) Month Year Grade (1-12)

List the most recent time the student was enrolled in a Colorado public school (NOT including preschool and kindergarten) Month Year Grade (1-12)

Is your child presently under an expulsion order from any other school district? Yes No

Is your child presently under consideration for expulsion? Yes No

Is your child presently involved in the Juvenile Justice system? Yes No

ELA Information

Please complete the Home Language Questionnaire included in this packet. If one IS NOT included, please contact the school secretary.

Special Services Information

Is your child receiving special education services? Yes No

Does your child have a current 504 plan? Yes No if yes, please indicate if related to: Academics Health

Was your child in any Gifted/Talented programs? Yes No if yes, please list

Does your child have any medical alerts? Yes No if yes, please explain on Registration Form page 4.

Parent/Guardian Signature: Date:

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Registration Form – Student Emergency Information  
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Student Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_

**Student Lives With:** Please check one box

Both Parents       Mother Only       Father Only       Mother/Stepfather       Father/Stepmother   
Foster Parents       Relatives  \_\_\_\_\_      Other  \_\_\_\_\_

Note: When a student does not reside with both parents, additional information must be on file so that the school can determine who is responsible for the student. If there are applicable legal documents, such as custody papers, a copy should be provided to the school. Where the arrangement is less formal, the school will provide the necessary form(s) for the parent/guardian to complete.

**Parent/Guardian Emergency Contact Information**

Emergency Contact # 1  2  3  4  (check only one)

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Legal Guardian  
Yes  No

Resident Address: \_\_\_\_\_

Household Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Emergency Contact # 1  2  3  4  (check only one)

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Legal Guardian  
Yes  No

Resident Address: \_\_\_\_\_

Household Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_

Additional Information: \_\_\_\_\_

**Parents Not Living with the Student**

Emergency Contact # 1  2  3  4  (check only one)

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Legal Guardian  
Yes  No

Resident Address: \_\_\_\_\_

Household Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Emergency Contact # 1  2  3  4  (check only one)

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Legal Guardian  
Yes  No

Resident Address: \_\_\_\_\_

Household Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_

Additional Information: \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Student Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_

Other Emergency Contact Information

Emergency Contact # 1  2  3  4  5  6  (check only one)

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Household Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Emergency Contact # 1  2  3  4  5  6  (check only one)

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Household Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Emergency Contact # 1  2  3  4  5  6  (check only one)

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Household Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Emergency Contact # 1  2  3  4  5  6  (check only one)

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Household Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell Telephone: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher/Counselor \_\_\_\_\_  
Room # \_\_\_\_\_  
Session: AM    PM

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Registration Form – Student Health Information  
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Student Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_

**Medical Alerts (Asthma, Allergies, etc).**

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Medical Alert 1: \_\_\_\_\_

Medical Alert 2: \_\_\_\_\_

**Medication Information**

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Is your child taking any medication regularly?    Yes     No

If yes, please list the medication(s): \_\_\_\_\_

Is your child allergic to any medication(s)?    Yes     No

If yes, please list the medication(s): \_\_\_\_\_

Indicate allergic reaction: \_\_\_\_\_

*Student Medication Request Release Agreements are available at the school office. This form must be completed for any medication a student will need to take during school hours.*

**Immunization Information**

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*In order for your child to attend school, immunization documentation needs to be on file at the school by the first day of attendance. If immunization documentation is **NOT** complete, the student **MUST** see the school nurse or designee before enrollment can be completed.*

**Doctor/Primary Care Provider**

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Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Extension: \_\_\_\_\_

Hospital: \_\_\_\_\_

In an emergency situation, the student will be transported to the nearest hospital and/or if the parents hospital of choice is on divert, the Emergency Personnel will select the alternative site.

If a parent or legal guardian cannot be notified and immediate medical care is indicated, the school will call 911. However, the Denver Public Schools will in no case accept financial responsibility for care.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This form will be given to the Nurse after registration**

Teacher/Counselor \_\_\_\_\_  
 Room # \_\_\_\_\_  
 Session: AM  PM

**Denver Public Schools**

School: \_\_\_\_\_  
**Registration Form – Student Health Information**  
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**Student Name:** \_\_\_\_\_ **Student ID#:** \_\_\_\_\_

**Health Concerns** Parents/Guardians are responsible for providing full details on any medical condition to the school nurse

Any problems during pregnancy or delivery? (Examples: Maternal health issues, C-section, Prematurity, etc.) Yes  No

Any problems during infancy? (Examples: Feeding difficulties, sleep disturbances, colic, developmental delays, illnesses, etc.) Yes  No

What age did your child first walk alone? \_\_\_\_\_ What age did your child first talk? (2 words together) \_\_\_\_\_

**Does your child have a health problem?**

Check and explain where appropriate	Medication(s)	Medication Given At Home		Medication Given At School	
		YES	NO	YES	NO
<input type="checkbox"/> Allergies					
<input type="checkbox"/> Asthma					
<input type="checkbox"/> Attention Deficit Disorder					
<input type="checkbox"/> Bowel/Bladder					
<input type="checkbox"/> Diabetes					
<input type="checkbox"/> Emotional/Behavioral					
<input type="checkbox"/> Fractures					
<input type="checkbox"/> Head Injury					
<input type="checkbox"/> Hearing					
<input type="checkbox"/> Headaches					
<input type="checkbox"/> Heart					
<input type="checkbox"/> Hyperactivity					
<input type="checkbox"/> Seizures or Fainting					
<input type="checkbox"/> Skin Conditions					
<input type="checkbox"/> Sleep Apnea					
<input type="checkbox"/> Speech					
<input type="checkbox"/> Surgeries / Hospitalizations					
<input type="checkbox"/> Tuberculosis					
<input type="checkbox"/> Varicella (Chickenpox)					
<input type="checkbox"/> Vision					
<input type="checkbox"/> Other					

Student has **NO** health concerns

**Please Check all that apply**

- Glasses  Contacts  Hearing Aids  
 Prosthesis or Physical Aids (please list) \_\_\_\_\_  
 Other \_\_\_\_\_

Information obtained on the Health History is solely used by the school nurse to ensure that sound decisions are made to meet the health needs of your student. Health information will **only** be shared with school staff on a "needs to know basis" and parents/guardians will be included in this process. Health information will not be shared with any other outside health providers without the expressed written permission of the parent/guardian. If you have any questions or concerns please contact your student's school nurse.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**This form will be given to the Nurse after registration**