

# Enrollment Checklist

Student: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Enrollment Date: \_\_\_\_\_

Time: \_\_\_\_\_

**PLEASE CONTACT \_\_\_\_\_ TO SCHEDULE  
AN ENROLLMENT APPOINTMENT. XXX-XXX-XXXX**

√ Documents/Procedures Mandated by Maryland State Department of Education	√ Documents/Procedures Mandated by Maryland State Department of Education
FCPS Enrollment Form	Special Education/ 504 Plan Documentation: A copy of the IEP or 504 Plan
<b>Withdrawal Form:</b> <ul style="list-style-type: none"> <li>• Notify the sending school that the student is leaving.</li> <li>• Obtain a withdrawal form from the sending school.</li> </ul>	<b>Release of Information/Records Request form:</b> <ul style="list-style-type: none"> <li>• A signed copy will be sent to the sending school to request that copies of all records be sent to us.</li> </ul>
<b>Proof of Date of Birth:</b> One of the following documents must be provided: <ul style="list-style-type: none"> <li>• birth certificate,</li> <li>• passport/visa,</li> <li>• hospital certificate,</li> <li>• baptismal or church certificate,</li> <li>• parent's notarized affidavit.</li> </ul>	<b>Supplemental Enrollment Information for Athletic Eligibility:</b> <ul style="list-style-type: none"> <li>• Provide a copy of the last report card received and complete the Athletic Eligibility form.</li> <li>• This form is required to participate in sports, clubs, activities, field trips, etc.</li> </ul>
<b>Proof of Residency:</b> One of the following documents, which <u>includes parent/guardian's name and address</u> , must be provided: <ul style="list-style-type: none"> <li>• current property tax bill,</li> <li>• current rental/lease agreement,</li> <li>• purchase contract for new home or</li> <li>• current utility bill (gas, water or electric) Please note that cable tv &amp; phone bills are not approved documentation.</li> <li>• If parent/legal guardian is not able to provide proof of residency in his/her name, then a Parent Residency Affidavit/ Multi-family Disclosure form must be completed, notarized and submitted with proof of residency from the owner of the home.</li> </ul>	<b>Proof of Immunization:</b> <ul style="list-style-type: none"> <li>• Proof of vaccinations can be obtained from current school or doctor's office.</li> <li>• If a vaccination is missing, parent/guardian must provide proof of an appointment for vaccination in order to attend school.</li> <li>• Students transferring from out of state must complete a Health Inventory and get a physical within the first 6 months of enrollment.</li> <li>• Students transferring within Frederick County should have a physical prior to entering 9<sup>th</sup> grade</li> </ul>
<b>Transcript/Grades:</b> <ul style="list-style-type: none"> <li>• Obtain a current unofficial high school transcript. (Incoming 9<sup>th</sup> graders may provide a copy of the 8<sup>th</sup> grade report card or middle school transcript.)</li> <li>• This documentation is essential in verifying grade status and credits needed for high school graduation.</li> <li>• A copy of any state/local test scores would also prove beneficial.</li> </ul>	<b>Proof of Custody:</b> <ul style="list-style-type: none"> <li>• A parent/legal guardian is the only person who may enroll a student.</li> <li>• Aunts, uncles, grandparents, step-parents, family friends, etc. may not enroll a student without proof of guardianship.</li> <li>• The parent/legal guardian must present a photo ID at the enrollment appointment.</li> <li>• One of the following documents must be provided for proof of custody:               <ul style="list-style-type: none"> <li>o birth certificate that includes parent's name,</li> <li>o legal documentation that reflects custody by someone other than a parent,</li> <li>o divorce decree that specifies custody.</li> </ul> </li> </ul>



Enrollment Date	Student ID#	School Name	Bus #
Enrollment Code	Teacher Name	School #	Walker

# FCPS **FREDERICK COUNTY PUBLIC SCHOOLS ENROLLMENT FORM**

THE FOLLOWING ITEMS ARE REQUIRED BY MARYLAND LAW BEFORE A STUDENT CAN ATTEND/ENROLL IN SCHOOL.

If you are missing any of the following information please see the secretary.

- Proof of Date of Birth *Birth Certificate, Physicians Certificate, Church Certificate, Passport/Visa/Hospital Certificate, Parent Affidavit*
- Proof of Residency *Signed Lease Agreement, Utility Bill (electric/water/gas). NOT ACCEPTED: Phone bills, cable bills*
- Proof of Immunizations

Legal Name of Student: \_\_\_\_\_  
First Name                      FULL Middle Name                      Last Name                      Gender                      Date of Birth

Home Phone Number: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's Preferred Name or Nickname (optional): \_\_\_\_\_

EVIDENCE OF DATE OF BIRTH (Check one. School will retain a copy.)

- Birth Certificate   
 Physician's Certificate   
 Church Certificate   
 Passport/Visa   
 Hospital Certificate  
 Parent's Affidavit   
 Other (specify) \_\_\_\_\_

RACE: (check all that apply):   
 American Indian/Alaskan Native   
 Asian   
 Black or African American   
 White  
 Native Hawaiian or other Pacific Islander

ETHNICITY: Is the student Hispanic or Latino?   
 Yes   
 No                      Country of Birth: \_\_\_\_\_

What language(s) did the student first learn to speak? \_\_\_\_\_

What languages does the student use most often to communicate? \_\_\_\_\_

What language(s) are spoken in your home: \_\_\_\_\_

STUDENT ADDRESS: Please include a street address with PO Boxes

House Number / Street Name / Apartment Number / PO Box

City / State / Zip Code

DWELLING TYPE:   
 Apartment/Condo   
 Townhouse/Duplex   
 Single Family / Detached

Is this address out-of-district?   
 Yes   
 No    *If yes, school will refer to PPW*

LEGAL PARENT/GUARDIAN INFORMATION Enter one guardian in each area. Enter PRIMARY CONTACT FIRST.

Legal Parent/Guardian Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Address (if different from student): \_\_\_\_\_

House Number / Street Name / Apartment Number / PO Box

City / State / Zip Code

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

Email: \_\_\_\_\_

Legal Parent/Guardian Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Address (if different from student): \_\_\_\_\_

House Number / Street Name / Apartment Number / PO Box

City / State / Zip Code

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

Email: \_\_\_\_\_

Is there a court order concerning custody?   
 Yes\*\*   
 No   
 Not applicable

Type of proof of custody and/or guardianship, e.g., court / legal documents: \_\_\_\_\_

Is there a "NO CONTACT" order?   
 Yes\*\*   
 No

\*\*FCPS must have a copy of any court orders relating to CUSTODY or NO CONTACT in order to honor the request.

**ADDITIONAL STUDENT INFORMATION**

Will you allow your child's name to be published? (e.g., newspaper, FCPS television broadcasts, Honor Roll)   
 Yes   
 No

Is the current address a temporary living arrangement?   
 Yes   
 No

If yes, is this current living arrangement due to lack of housing or economic hardship?   
 Yes   
 No

**PRIOR SCHOOL INFORMATION**

School Last Attended: \_\_\_\_\_ Date(s) Last Attended: \_\_\_\_\_  
Address: \_\_\_\_\_  
Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Is your child currently attending, or has your child ever attended a Maryland Public-School?  Yes  No

If YES, please provide school district name: \_\_\_\_\_

Is the student currently expelled or suspended from another school?  Yes  No *If yes, school will refer to PPW*

Is the student transferring from an alternative school?  Yes  No *If yes, school will refer to PPW*

**SPECIAL SERVICES**

Was your child enrolled in a special program?  Yes  No

If yes, please specify:  Special Education: Hours of service: \_\_\_\_\_  504 Plan  Student Support Teacher Services

Court Placement: \_\_\_\_\_ Residential \_\_\_\_\_ Other

English Language Learner Specify one: \_\_\_\_\_ Beginner \_\_\_\_\_ Intermediate \_\_\_\_\_ Advanced

**EMERGENCY CONTACTS (OTHER THAN LEGAL PARENT/GUARDIAN)**

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

Address (if different from student): \_\_\_\_\_  
House Number / Street Name / Apartment Number City / State / Zip Code

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

Email: \_\_\_\_\_

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

Address (if different from student): \_\_\_\_\_  
House Number / Street Name / Apartment Number City / State / Zip Code

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

Email: \_\_\_\_\_

**DAY CARE PROVIDER:**

Name \_\_\_\_\_ House Number / Street Name \_\_\_\_\_ City / State / Zip Code \_\_\_\_\_  
Phone Numbers: \_\_\_\_\_ (home) \_\_\_\_\_ (cell)

**OTHER HOUSEHOLD MEMBERS**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to student \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to student \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to student \_\_\_\_\_

**HEALTH CONCERNS (e.g., takes daily medications, wears glasses, hearing problem, allergies, diabetic, etc.)**

Describe: \_\_\_\_\_

**Immunization records on file?**  Yes  No

Has the child received a physical examination in the past 9 months?  Yes  No

Is DHMH on file?  Yes  No If no, give reason:  Insufficient financial resources  Lack of access to care

**Community Services (optional):** If your family has been in contact and/or has received services from outside agencies, please indicate (e.g., Mental Health, Social Services, Community Agency School Services (CASS): \_\_\_\_\_

**DISCLAIMER:** Your son/daughter \_\_\_\_\_ has been enrolled on the basis of available information. Upon receipt of all records and information, formal enrollment will be completed. Any person who willfully makes a material misrepresentation shall be subject to a penalty payable to the County for three times the pro rata share of tuition for the time the child fraudulently attends a Frederick County Public School.

\*Contact information provided in this document will be used by authorized FCPS and Frederick County Health Department (FCHD) employees to contact parent(s)/guardian(s) of students when necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# URBANA HIGH SCHOOL

Student Services Suite  
3471 Campus Drive  
ljamsville, Maryland 21754  
Phone: 240-236-7623 Fax: 240-236-7602

## REQUEST FOR RECORDS

Previous School Name: \_\_\_\_\_

Previous School Address: \_\_\_\_\_

**Previous School FAX #** \_\_\_\_\_

Dear Registrar:

The student below has registered in our school. Public Law 93-380 and Maryland by-law 13/07/05/18 does not require the school forwarding pupil records to obtain parent permission to release records. Please send the following records at your earliest convenience.

- ◆ Academic transcript (including attendance)
- ◆ Test Information (including psychological evaluations)
- ◆ Health Records (including immunization information)
- ◆ Special Education Files
- ◆ Current year report card(s) and grades at the time of withdrawal
- ◆ If planning to participate in sports, we must have last term report card

All Maryland schools are required to send original records, not copies. Thank you in advance for your prompt reply to this request.

Sincerely,

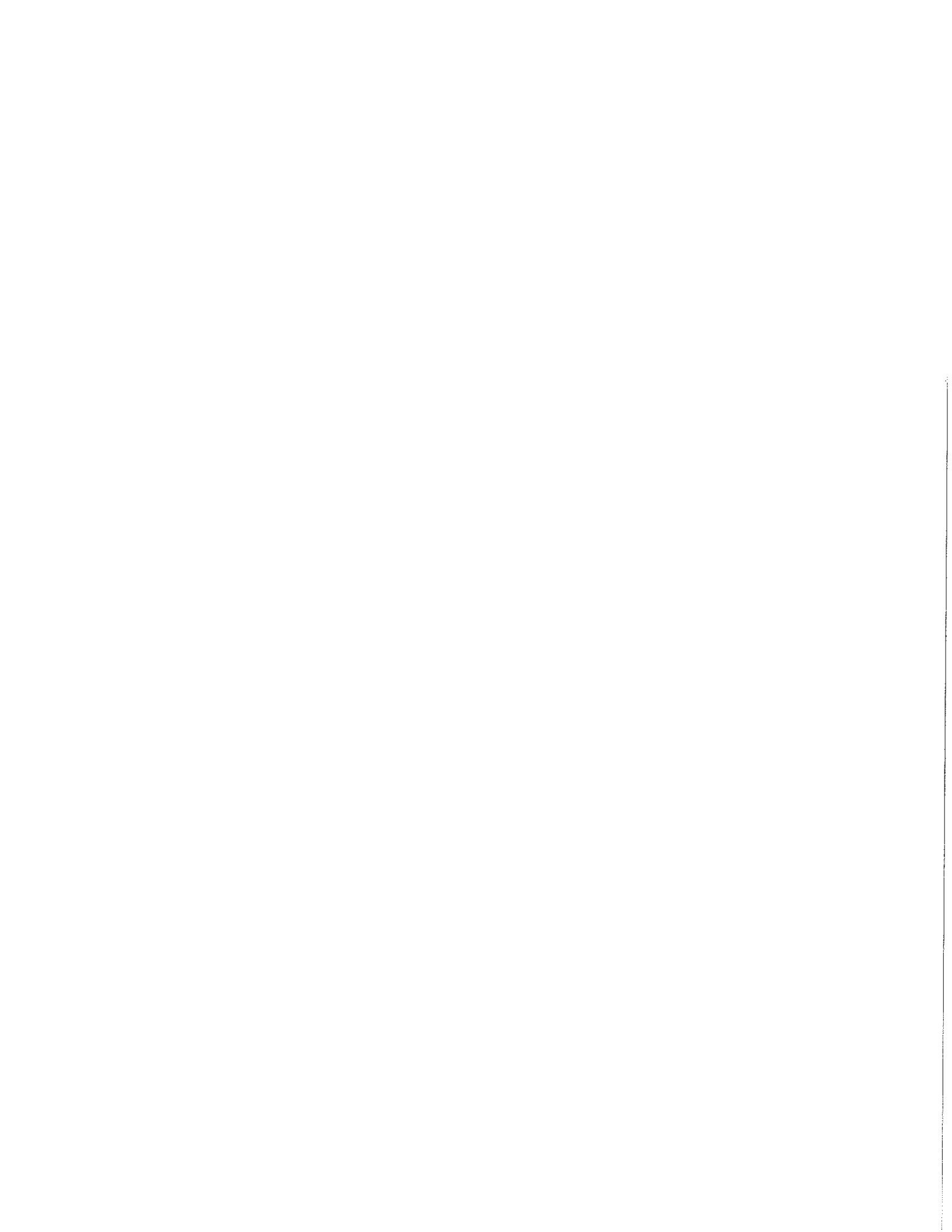
Sheri Jiron  
Registrar



Last Name	First Name	Middle Initial	Birth Date	Grade
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I hereby grant Urbana High School permission to secure the above specified information from other schools of attendance.

Parent's Signature	Date	Student's Signature	Date
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# **PROOF OF RESIDENCE INSTRUCTIONS**

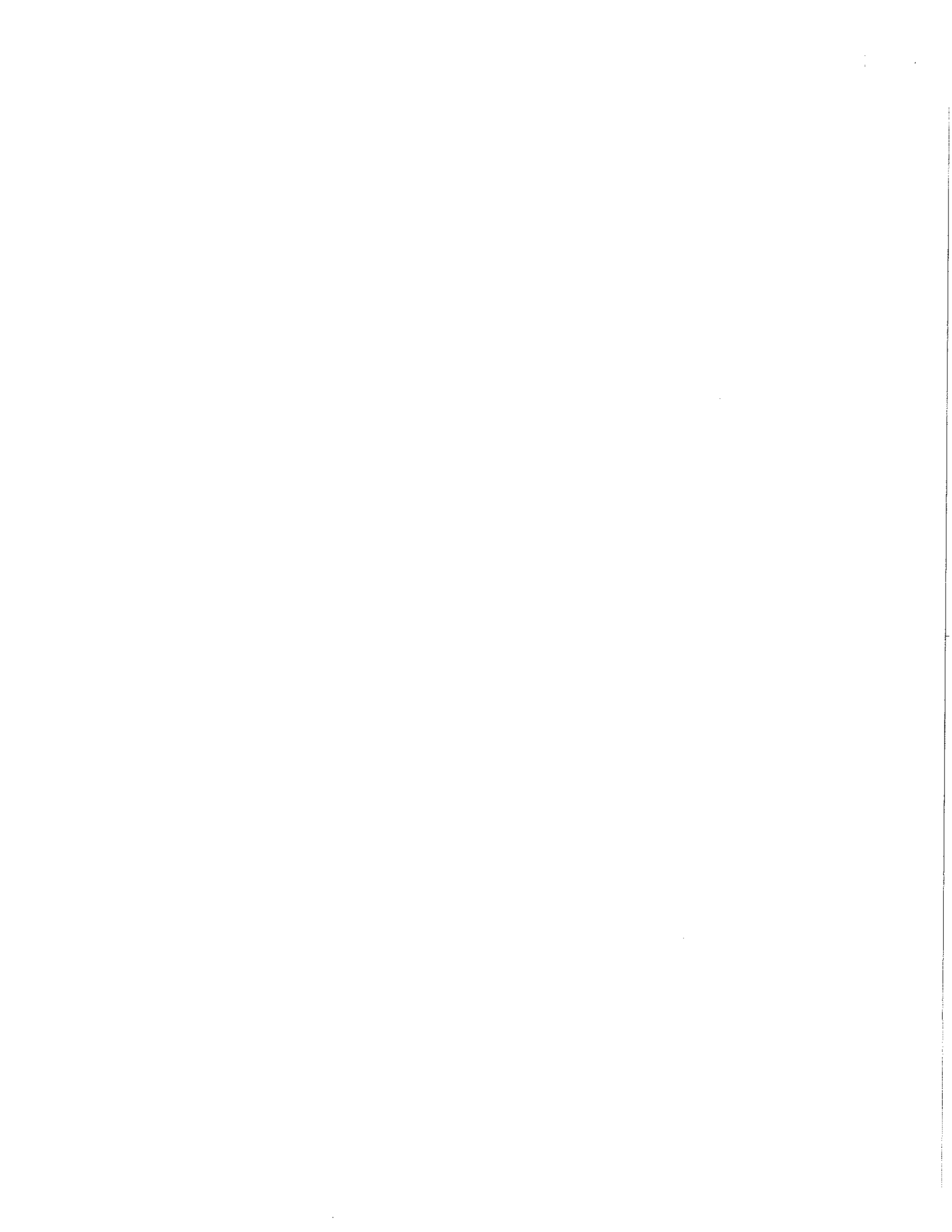
**One of the following documents (which must include parent/guardian's name and address) must be provided:**

- **Current utility bill (gas, water or electric). Please note that cable tv and phone bills are not approved documentation.**
- **Current property tax bill**
- **Current rental/lease agreement**
- **Purchase contract for a new home**

**If you cannot provide current proof of residency in your name, then you and the owner of your home must complete a Multi-Family Disclosure form. Please request this form from the Registrar, fill it out, have it notarized and submit it along with one of the items listed above from the owner.**

**If you do not live in the UHS district, you must also submit a copy of your Out-of-District approval letter in addition to your proof of residency as listed above.**

**Thank you!**





MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME \_\_\_\_\_  
 LAST FIRST MI

SEX: MALE  FEMALE  BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_

COUNTY \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT NAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
 OR  
 GUARDIAN ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Dose #	Vaccines Type									Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr						
1										1				
2										2				
3											Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4											_____	_____	_____	_____
5											_____	_____	_____	_____

To the best of my knowledge, the vaccines listed above were administered as indicated.

Clinic / Office Name  
 Office Address/ Phone Number

- Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
(Medical provider, local health department official, school official, or child care provider only)
- Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_
- Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Lines 2 and 3 are for certification of vaccines given after the initial signature.

**LOST OR DESTROYED RECORDS:** (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

**MEDICAL CONTRAINDICATION:**

The above child has a valid medical contraindication to being immunized at this time.

This is a  permanent condition  temporary condition until \_\_\_\_/\_\_\_\_/\_\_\_\_

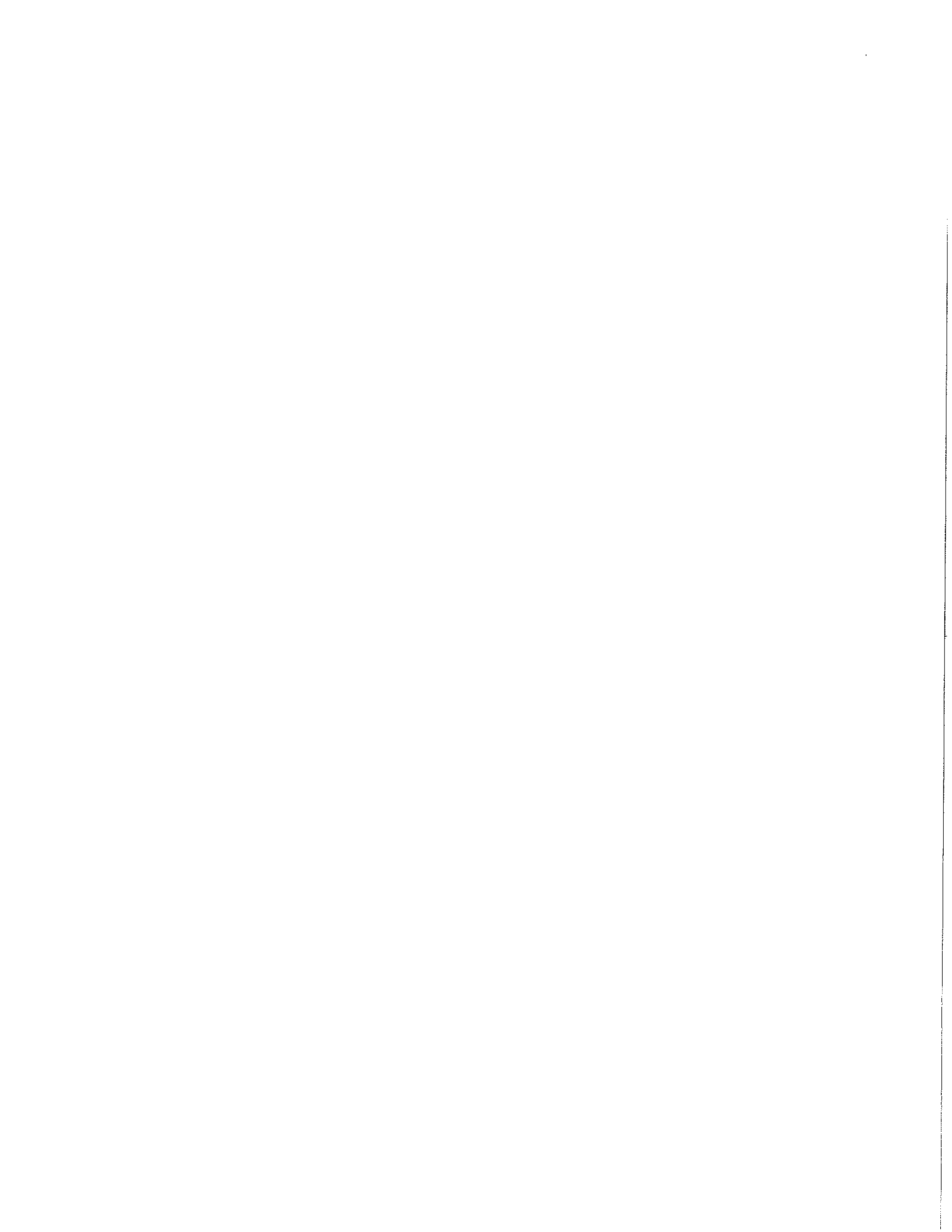
Check appropriate box, indicate vaccine(s) and reasons: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 Medical Provider / LHD Official

**RELIGIOUS OBJECTION:**

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



### CONFIDENTIAL HEALTH INFORMATION

In case of an emergency, the school staff will contact 911.  
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION					
Last:	First:	Middle:	Date of Birth:	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Grade
School Name:					
Does the student have health insurance? <input type="checkbox"/> Private <input type="checkbox"/> Medical Assistance <input type="checkbox"/> No Insurance			Does the student have dental insurance? <input type="checkbox"/> Y <input type="checkbox"/> N		

CURRENT HEALTH CONCERNS	
<i>Please check the following health concerns that may impact the student's educational day. This information may be shared with FCPS staff as appropriate.</i>	
<input type="checkbox"/> The student does not have any medical concerns	
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> cancer
<input type="checkbox"/> allergies (choose all that apply)	<input type="checkbox"/> diabetes
<input type="checkbox"/> foods _____	<input type="checkbox"/> hearing problems <input type="checkbox"/> hearing aid(s)
<input type="checkbox"/> bee sting/insect bite _____	<input type="checkbox"/> heart problems _____
<input type="checkbox"/> medicines _____	<input type="checkbox"/> mental health diagnosis _____
<input type="checkbox"/> pesticides/chemicals* _____	<input type="checkbox"/> physical disability _____
<input type="checkbox"/> other _____	<input type="checkbox"/> seizures
<input type="checkbox"/> asthma: Has the student experienced an asthma episode in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> vision problems _____
<input type="checkbox"/> blood disorder _____	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
<input type="checkbox"/> other _____	<input type="checkbox"/> other _____
<input type="checkbox"/> This information is a change in health condition from the last school year	
<small>*FCPS uses the Integrated Pest management programs to identify and control pest problems in schools. Elementary schools must notify staff and parents/guardians of all students 24 hours before pesticides are to be applied inside the school building or on the grounds. Middle and high schools must notify only those parents, guardians or staff who have filed a written request for notification; forms are available at each school and must be updated every school year. See the FCPS Calendar Handbook for details, or contact your child's school.</small>	

MEDICATIONS	
List all medications and dosages your child receives on a routine basis	
<input type="checkbox"/> Medications are not required at school	
<i>If the student requires over-the-counter or prescription medications or treatments at school, the health care provider and parent must complete and submit the appropriate authorization form(s). Obtain forms from the health staff at your child's school or at <a href="http://www.fcps.org/">http://www.fcps.org/</a> (click on Forms).</i>	
Medications: _____	
_____	

<i>I hereby give authorization and consent to the school, in the event that I cannot be contacted, to obtain emergency medical care and necessary emergency transportation to a healthcare facility. I understand and authorize that my child's medical records or other medical information, furnished to the school, will be shared with FCPS/Frederick County Health Department staff and emergency personnel who have a legitimate medical/educational purpose for accessing such medical records and information.</i>	
Parent/Guardian name (please print): _____	Primary Contact Ph# _____
Signature of Parent / Guardian: _____	Date _____

