Zumbro Education District
Area Learning Center
630 First Avenue NW
Byron, MN 55920

Today's Date:_____

Student Registration Form

INSTRUCTIONS: Please **print clearly** and **answer every item**. Incomplete applications cannot be processed.

☐ New ☐ Returning Start Date:_____

Student Name:_____
Last, First Middle

☐ Male ☐ Female Grade: _____ Birth Date _____/_____/_____

(All student information & mailings will be sent to the primary household.)

Parent(s)/Guardian(s) Name(s):_____
(List only those having legal custody) *relationship(s) to student*

Primary Parent(s)/Guardian(s) Address:

_____
Street Address City, State, Zip Code

_____
Mailing Address *(if different than above)* City, State, Zip Code

County:_____ E-mail address to use for Parent/Guardian contact:_____

Mom/Guardian: Home:_____ Cell: _____ Work: _____

Dad/Guardian: Home:_____ Cell: _____ Work: _____

Student: Home:_____ Cell: _____ Work: _____

Secondary Parent/Guardian:_____
(if different than Primary) *Name* *Relationship*

_____
Street Address City, State, Zip Code

_____
Mailing Address (*if different than above)* City, State, Zip Code

Home:_____ Cell: _____ Work: _____

Emergency Contacts other than Primary or Secondary Parent(s)/Guardian(s):

_____
Name Relationship Phone

_____
Name Relationship Phone

Resident School District of Enrollment:_____

Is student open enrolled? YES ☐ NO ☐ , if yes – Open Enrolled to which district:_____

Last School District Attended:_____ Dates_____

Transportation: Bus ☐ Drive ☐ Other _____ Make and Color of Vehicle _____

In order to comply with federal and state civil rights laws, schools must collect the following data.

Ethnicity: Is this student (or are you) Hispanic / Latino?

_____ No, not Hispanic / Latino

_____ Yes, Hispanic / Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin)

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 student's (or your) race to be.

Race: What is student's (or your) race? *(Choose one or more)*

_____ 1. **American Indian or Alaska Native**
(person having origins in any of the original peoples of North and South America (incl. Central America), and who maintains tribal affiliation or community attachment)

_____ 2. **Asian**
(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)

_____ 3. **Black or African American**
(person having origins in any of the black racial groups of Africa)

_____ 4. **Native Hawaiian or Other Pacific Islander**
(person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.)

_____ 5. **White**
(person having origins in any of the original peoples of Europe, the Middle East or North Africa)

High School Graduation Incentive Programs:

Minnesota Statute 124D.68, Subdivision 1 states: The legislature finds that it is critical to provide options for children to succeed in school. Therefore, the purpose of this section is to provide incentives for and to encourage Minnesota students who have experienced or are experiencing difficulty in the traditional education system to enroll in alternative programs.

Subdivision 2: The following pupils are eligible to participate in the high school graduation incentives program:

PLEASE CHECK ALL THAT APPLY:

A) Any pupil under the age of 21 who:

___ 1. performs substantially below the performance level for pupils of the same age in a locally determined achievement test;
___2. is at least one year behind in satisfactorily completing coursework or obtaining credits for graduation;
___3. is pregnant or is a parent;
___4. has been assessed as chemically dependent;
___5. has been excluded or expelled according to sections 121A.40 to 121A.56;
___6. has been referred by a school district for enrollment in an eligible program or a program pursuant to section 124D.69;
___7. is a victim of physical or sexual abuse;
___8. has experienced mental health problems;
___9. has experienced homelessness sometime within six months before requesting a transfer to an eligible program;
___10. speaks English as a second language or has limited English proficiency; or
___11. has withdrawn from school or has been chronically truant

Student Name (print)_____ Student Signature_____ Date _____

Parent/Guardian Name (print)_____Parent/Guardian Signature _____ Date _____

ZUMBRO EDUCATION DISTRICT
Blooming Prairie
Byron
Hayfield
Kasson-Mantorville
Pine Island
Stewartville
Triton

Zumbro Education District
Area Learning Center
630 1st Ave. NW
Byron, MN 55920
Ph: 507-775-2083 Fax: 507-775-2168
Website: www.zumbroed.org

PHOTO/VIDEO/WEBSITE RELEASE FORM

Dear Parent/Guardian:

On occasion, representatives from and/or employees of Zumbro Education District wish to photograph, videotape, and /or interview individuals in connection with school programs, projects, or events. In order to release photographs, video footage, and /or comments, and /or to post on the ZED or school websites, we need written permission.

To give your consent, please complete the form below:

I give permission for my child, _____ to be photographed, videotaped, and/or interviewed by representatives from and/or employees of the Zumbro Education District for the media for educational or public relations purposes.

Signature of parent or guardian: _____ Date: _____

OR

I am 18 years of age or older and I give my consent without reservations to the foregoing on my own behalf.

Signature of subject: _____ Date: _____

ZUMBRO EDUCATION DISTRICT — Blooming Prairie, Byron, Hayfield, Kasson-Mantorville, Pine Island, Stewartville, Triton	**CONSENT TO RELEASE PRIVATE DATA**	☐**South Campus** 221 2nd Ave SW, Byron MN 55920 Phone: 507-775-2108 Fax: 507-775-2344 ☐**Area Learning Center/Transitions** 630 1st Ave NW, Byron MN 55920 Phone: 507-775-2083 Fax 507-775-2168

Student's Full Legal Name: _____ **Birthdate:** _____ **Age:** ___

Parent Name(s): _____

Primary Parent Address: _____ Phone: _____

I authorize Zumbro Education District # 6012, Byron MN: (Check either or both boxes, as needed)

☐ **To Release Information To** ☐ **To Obtain Information From:**

Name/ Title/Organization:_____

Address: _____

Information to be shared:

☐ Health Records

☐ Psychological / Psychiatric Records and/or Reports

☐ County Social Work / Law Enforcement Report

☐ Medical Reports (including related services)

☐ Chemical Abuse / Dependency Report

☐ Counselor, Teacher, Staff Observations

☐ Official School Records (Name, Address, Birth date, Sex, Attendance Record, Grade Level, Grades, Class Rank, Standardized Test Results, Behavior Report)

☐ Other (Specify) _____

The purpose for the request _____

I understand that this authorization takes effect the day that I sign it. It expires on (date)_____ or no more than one year from the date of my signature. I also understand that I may change this authorization at any time.

I also understand that I may revoke this authorization at any time by providing a signed, written notice of revocation to the ZED School District. A photocopy or facsimile of this authorization has the same legal effect as the original.

In the case of protected health or medical information, I hereby authorize the healthcare provider to discuss, disclose, and otherwise release any and all medical records, medical data, and health data identified above to the ZED School District and its staff and representatives pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations, 45 C.F.R. 164.508. I understand that the healthcare provider may not condition treatment, payment, enrollment or eligibility on whether I execute this authorization. Health and medical information that is disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by the privacy regulations promulgated pursuant to HIPAA. Records that are received by the School District may be protected from re-disclosure under the Family Education Rights Privacy Act and the Minnesota Government Data Practice Act.

_____ _____

Parent / Guardian Signature, or Student if age 18 or older **Date**

SCHOOL HEALTH INFORMATION FORM

Name _____ Birthdate ____/____/____ Gender M F

Parent Name_____ Home Phone _____ Alt Phone _____

School _____ Grade _____ Email _____

HEALTH CONDITIONS (Check any of the following if they apply to your student)

____ ADD ____ ADHD ____ Medication at home:_____ ____ Medication at school:_____	____ Emotional/Behavior problems Describe:_____ Medication:_____
____ Allergies: List:_____ ____ Medication at home:_____ ____ Medication at school:_____ Anaphylactic (life threatening) reaction: Yes___No___ Epi-Pen: Yes___ No___	____ Headaches--frequent/severe ____ Migraines Medication at home:_____ Medication at school:_____
____ Asthma *Causes:* Exercise___ Allergies___ Colds___ Other_____ ____ My child has used asthma medications in the last 2 years ____ Medication at home:_____ ____ Medication at school:_____ Last Episode:_____ Last hospitalization for Asthma:_____	____ Seizures/Convulsions Type:_____ Last known:_____
____ Bone or joint conditions	____ Learning problems
____ Dental/Orthodontic problems	____ Lung/Breathing problems
____ Diabetes	____ Pain/Discomfort--frequent/severe
____ Ear/Hearing problems	____ Permanent or long-term disability
____ Eye/Vision problems	____ Serious Injury
____ Food restrictions/Special Diet:_____	____ Skin Conditions
____ Heart/Cardiovascular conditions	____ Stomach/Intestinal/Abdominal conditions
____ Infections--frequent/severe	____ Weight concerns/Eating Disorders
____ Kidney/Bladder conditions	____ Other

For any conditions checked above, please specify the current status, treatment, medication, care, and history.

_____

_____

Does child wear glasses/contacts? ___Yes ___ No **Are they to be worn at school?** ___Yes ___ No

Date of last professional eye exam: _____/____/_____ Results:_____

Does child have any activity restrictions? ___ Yes ___ No

Is child taking any medication not listed above? ___ Yes ___ No @ ___ Home ___ School Specify:_____

Do you want to schedule a conference with the School Public Health Nurse to discuss any particular health concerns? ___ Yes ___ No

Indicate your concern: ___ Medications ___ Emergency Plan ___ Other:_____

Additional information you care to share:_____

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.

_____ _____

Signature of Parent/Guardian Date

FOR HEALTH OFFICE USE:

Reviewed by:_____

Date reviewed:_____

Charted by:_____

Date charted:_____