



# ELP/KINDERGARTEN REGISTRATION FORM

Full Legal Name of Student: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Preferred Name/Nickname: \_\_\_\_\_

Students Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_ Gender:  Male  Female

Mother's/Guardian's Name: *if guardian, please state relation to student*

Physical Address and/or Mailing Address:

E-mail: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Father's/Guardian's Name: *if guardian, please state relation to student*

Physical Address and/or Mailing Address

E-mail: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

PHONE: Please indicate what numbers to call during school hours. (mark with an X)			
Home:			
Cell:			
Work:			
Legal Guardian		Lives with	
Y	N	Y	N
Receive Mailings		Auth. to pick up	
Y	N	Y	N

PHONE: Please indicate what numbers to call during school hours. (mark with an X)			
Home:			
Cell:			
Work:			
Legal Guardian		Lives with	
Y	N	Y	N
Receive Mailings		Auth. to pick up	
Y	N	Y	N

**\*\* PLEASE INFORM THE SCHOOL OF ANY CHANGES THROUGHOUT THE SCHOOL YEAR \*\***

Siblings (complete this section only if applicable. Include only siblings who currently attend Clinton School)

Full name: \_\_\_\_\_ Grade: \_\_\_\_\_

Full name: \_\_\_\_\_ Grade: \_\_\_\_\_

Full name: \_\_\_\_\_ Grade: \_\_\_\_\_

## EMERGENCY CONTACTS

Name	Relation to Student	Home Phone;	Other Phone	Auth. to pick up	
				Y	N

**Legal bindings:** Please list any legal binding information including: restraining orders, custody agreements, parenting plans, etc. that may be pertinent to this student and his/her safety. *(Copy of legal documentation is required)*

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**Has this student ever received services, or been involved in:**

- Behavior Management       Counseling       Gifted Program       Reading/Math Tutor  
 Section 504       Speech Therapy       Special Education       Title I       ESL

### **Guidance on Race/Ethnicity Montana Office of Public Instruction (OPI)**

In accordance with new standards issued by the U.S. Department of Education (ED), schools across the nation must revise how they collect and report race and ethnicity for students. These revisions will make educational data consistent with the U.S. Census and other national data sets. The change in reporting is intended to make demographic information more accurate and to account for people who identify themselves as being part of more than one race in our diverse American society. This change is not optional for states. State educational agencies, local educational agencies, postsecondary institutions, and other educational institutions and Department grantees are required to report racial and ethnic data to the Department. All must use the categories set forth in the ED's 2007 final guidance starting with information for the 20102011 school year. The new standards make a separate distinction between race and ethnicity. Hispanic/Latino is considered an ethnicity, not a race. In general, the Census Bureau defines ethnicity as the heritage, nationality group, lineage, or country of birth of the person or the person's ancestors. People who identify their ethnicity as Hispanic or Latino may be of any race. Individuals will have the opportunity to select multiple races to more fully describe their heritage. Montana law 20-9-309(2)(g) MCA authorizes the OPI to collect race/ethnicity data. Funding is allocated to districts based in part on reporting student racial/ethnic data. Federal education funds are allocated using aggregate data reported to the U.S. Department of Education (ED). Some state funding, such as the American Indian Achievement Gap Payment, is also tied to demographic data.

Identify the ethnicity and race of the individual by answering **BOTH** questions below:

#### **Part 1.**

**Is the individual Hispanic or Latino?** *(Choose only one)*

- No, not Hispanic or Latino  
 Yes, Hispanic or Latino *(A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)*

#### **Part 2.**

**What is the individual's race?** *(Choose one or more races below)*

- American Indian or Alaska Native** *(A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)*
- 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, Vietnam and Laos.)*
- 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 or Caucasian** *(A person having origins in any of the original peoples of Europe, the Middle East or North Africa.)*

Is English the primary language in your home? (circle) **Yes** or **No** – please specify \_\_\_\_\_

**PLEASE SEE REVERSE SIDE** →

## ELP/Kindergarten Enrollment Questionnaire

At Clinton we believe the first year of school helps to build a solid foundation for a student's future. Please help us best meet your child's social, physical and academic needs by completing the following information.

\*\*This information is confidential\*\*

It is strictly used to help us become better acquainted with you and your child.

**Full Legal Name of Student:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Preferred Name/Nickname:** \_\_\_\_\_

**Students Date of Birth:** \_\_\_\_\_

**Grade:** \_\_\_\_\_ **Gender:**  Male  Female

**Name of person completing questionnaire:** \_\_\_\_\_

### FAMILY BACKGROUND

**HOUSEHOLD #1:**

Child lives with the following **ADULTS:**

NAME	RELATION	OCCUPATION/EMPLOYER
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Other Children in the household:**

NAME/RELATION	AGE	GENDER	GRADE
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

**HOUSEHOLD #2:**

Child lives with the following **ADULTS:**

NAME	RELATION	OCCUPATION/EMPLOYER
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Other Children in the household:**

NAME/RELATION	AGE	GENDER	GRADE
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

**\*\*If your child shares two households, is there a *legal parenting plan* in place?**  Yes  No (if yes, please provide copy)

Please list any **special living situations** that may help us better understand your child's daily schedule:

\_\_\_\_\_

**SOCIAL EXPERIENCES**

1. During the day, my child currently (check all that apply):

- is home with a parent                       is home with a sitter/nanny  
     full day     full day  
     half day     half day  
    # of days per week: \_\_\_\_\_                      # of days per week: \_\_\_\_\_

- attends daycare (Name of daycare and/or provider: \_\_\_\_\_)  
     full day  
     half day  
    # of days per week: \_\_\_\_\_

- attends preschool (Name of facility: \_\_\_\_\_)  
     full day  
     half day  
    # of days per week: \_\_\_\_\_

2. Has your child ever attended **preschool or a Head Start** program:  Yes     No

Name & location of preschool(s) attended:	Length of Experience:	Age of attendance:
	(6 mos, 2 yrs, etc)	
_____	_____	_____
_____	_____	_____
_____	_____	_____

May we contact the preschool(s) about your child?  Yes     No

3. Has your child previously attended Preschool/Kindergarten?  Yes     No

Name & location of preschool(s) attended:	Length of Experience: (6 mos, 2 yrs, etc)
_____	_____

**DEVELOPMENT**

(Feel free to add additional comments to your responses):

1. Child's birth weight: \_\_\_\_\_ Was the birth premature?  Yes     No  
    If yes, how many weeks premature? \_\_\_\_\_  
    Were there any complications during the pregnancy or delivery?  Yes     No  
    If yes, please explain: \_\_\_\_\_

2. At approximately what age did you child: Crawl? \_\_\_\_\_ Walk? \_\_\_\_\_

3. How often does your child spend time **looking** at books?  Often     Occasionally     Not often

4. Do you read to your child?  Yes     No    How often? \_\_\_\_\_

5. Is your child able to remember children's songs and nursery rhymes?  Yes     No

6. Has anyone in your child's **family** experienced reading difficulties?  Yes     No  
(optional) If yes, please describe: \_\_\_\_\_

7. Is your child right or left handed?  RIGHT       LEFT       NO DOMINANCE YET
8. Has your child had experience with scissors?  Yes, often     No, not at all     Only a few times

Does your child use scissors properly?

Meaning – he/she can cut fairly accurately along curved lines and around shapes (circle, square and triangle) and turn paper fairly effectively with his/her hand to stay on the line.

Yes     No

9. **Self-Help skills:** Please check the items below that **your child can do independently**

(most of the time, with no help):

- Buttons       Puts on jacket       Zips       Completely dresses/undresses self       Ties shoes
- Blows & wipes nose without being told       Uses bathroom (wipes independently)
- Routinely washes hands after toileting       When asked, cleans up after self (puts toys away, picks up items, cleans up after eating)

**\*\*These are great skills for your child to practice and have in place prior to starting Kindergarten!\*\***

10. Has your child ever received any services? (counseling, mental health, speech therapy, etc?)  Yes     No

Service(s) my child **once received**, but is no longer receiving (check all that apply):

- Counseling     Mental Health therapy     Speech therapy     Occupational therapy
- Physical therapy     Vision therapy     Foster Care     Other: \_\_\_\_\_

Service(s) my child is **currently receiving** (check all that apply):

- Counseling     Mental Health therapy     Speech therapy     Occupational therapy
- Physical therapy     Vision therapy     Foster Care     Other: \_\_\_\_\_

Names of agencies/providers currently helping child: \_\_\_\_\_

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### SCHOOL ADJUSTMENT

1. My child's attention level (excluding TV time/media time) can be described as:
- Always on the go
- Sometimes able to sit for 10 minute stretches
- Maintains interest in one activity for 20 minutes or more
2. Does your child listen without interrupting while someone else talks?  Yes     No
3. What is your child's regular bedtime? \_\_\_\_\_
4. How many hours per night does your child typically sleep? \_\_\_\_\_
5. How many **hours per day** does your child:
- Play independently (creative play, dramatic play, outside play – NOT including media time)? \_\_\_\_\_
  - Have access to screen time (tv, movies, computer, tablets, smartphone, video games)? \_\_\_\_\_
  - Naps? \_\_\_\_\_ hours
6. What three words best describe your child?

\_\_\_\_\_

7. **Parental Concerns:** Please check any areas you are concerned with regarding your child:

- Behavior**      \_\_\_ tantrums                      \_\_\_ is not able to accept limits                      \_\_\_ is very shy  
                         \_\_\_ resists or refuses requests      \_\_\_ easily frustrated                      \_\_\_ hits/shoves/bites  
                         \_\_\_ has trouble relating to other children                      \_\_\_ other: \_\_\_\_\_
- Social skills**      \_\_\_ does not play well with others                      \_\_\_ will not work in a group  
                         \_\_\_ does not separate from parent easily                      \_\_\_ is left out of peer activities  
                         \_\_\_ other: \_\_\_\_\_
- Speech/Language:** \_\_\_ speech is unclear or garbled                      \_\_\_ stutters  
                         \_\_\_ often needs instructions repeated                      \_\_\_ difficulty expressing needs/wants  
                         \_\_\_ other: \_\_\_\_\_
- Speech/Language:** \_\_\_ toilet difficulties or accidents                      \_\_\_ feeding or dressing issues  
                         \_\_\_ other: \_\_\_\_\_
- Attention:**      \_\_\_ distracted easily                      \_\_\_ short attention span  
                         \_\_\_ jumps from one thing to another                      \_\_\_ other: \_\_\_\_\_
- Developmental Delays:**      \_\_\_ is not learning at average rate                      \_\_\_ delays in developmental milestones  
                         \_\_\_ other: \_\_\_\_\_
- Movement:**      \_\_\_ clumsy                      \_\_\_ difficulty using tools                      \_\_\_ hand/eye coordination  
                         \_\_\_ poor control of body movement                      \_\_\_ other \_\_\_\_\_
- Hearing:**      \_\_\_ trouble hearing                      \_\_\_ asks other to repeat or talk louder                      \_\_\_ favors one ear  
                         \_\_\_ startles at sudden noises                      \_\_\_ frequent ear infections                      \_\_\_ other: \_\_\_\_\_
- Vision:**      \_\_\_ eyes cross or turn out                      \_\_\_ squints                      \_\_\_ rubs eyes                      \_\_\_ eyes quiver  
                         \_\_\_ tilts or turns head to focus on something                      \_\_\_ other: \_\_\_\_\_

8. List your child's strengths and/or interests: \_\_\_\_\_  
\_\_\_\_\_

9. How does your child feel about starting Kindergarten? (excited, nervous, no interested, etc.) \_\_\_\_\_  
\_\_\_\_\_

10. Is there anything else that you would like to share with us that may affect your child here at school? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you so much for your time! We look forward to getting to know your child and working together with you to create a successful Preschool/kindergarten year!



Please provide a copy of your child(ren)'s most up-to-date immunizations.

These can be obtained for your doctor's office.

**AND**

A certified copy of their birth certificate  
*(required prior to first day of classes)*

**ALSO**

**Please download the Infinite Campus app.**

On your smart phone. Or go to

<https://mtcloud3.infinitecampus.org/campus/portal/clinton.jsp> on  
your home computer.

This will allow you to keep track of lunch balances, grades, attendance and communicate with your child(ren)'s teacher!

**CLINTON ELEMENTARY SCHOOL**



School District #32

20397 E. Mullan Road

P.O. Box 250

Clinton, MT 59825-250

(406) 825-3113 • (406) 825-3114 Fax

**CUMULATIVE HEALTH RECORD**

Student Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Physician: \_\_\_\_\_ Dentist: \_\_\_\_\_

Pupil's Health (give approximate age)

Allergy, specify: \_\_\_\_\_

Under MD treatment? \_\_\_\_\_

Asthma: \_\_\_\_\_

Congenital defects (cleft lip, or palate, hip dysplasia)

\_\_\_\_\_

Diabetes (date of onset): \_\_\_\_\_

Epilepsy or Seizure Disorder (date of onset)

\_\_\_\_\_

Significant family history (diabetes, hypertension, etc.)

\_\_\_\_\_

Physical restrictions or health problems that may require special seating, bathroom privileges, etc.

\_\_\_\_\_

Special diet or food restrictions: \_\_\_\_\_

Current medications (name of medication and how often):

\_\_\_\_\_

\_\_\_\_\_

<p>Parent/Nurse/Teacher Comments</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<p>Ear Infections: _____</p> <p>Ear Tubes: (year inserted): _____</p> <p>Heart Condition, specify:</p> <p>_____</p> <p>_____</p> <p>Injuries: _____</p> <p>Surgery: _____</p> <p>Other:</p> <p>_____</p> <p>_____</p>
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*Please note: If this sheet was completed recently for new registration, another is not needed. Thank you.*

**EMERGENCY CONTACT INFORMATION IN CASE OF ILLNESS OR INJURY DURING SCHOOL**

**\*This sheet is kept in the student's medical file at school.\***

**Today's Date:** \_\_\_\_\_

**Student:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Teacher:** \_\_\_\_\_

**Health Problems/Concerns:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Mother's Name & Preferred phone:** \_\_\_\_\_

**Father's Name & Preferred phone:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_

**Alternate contacts if parent(s)/guardian(s) cannot be reached:**

**Name/Relationship to Student:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Name/Relationship to Student:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Name/Relationship to Student:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

Please inform these family members/friends that you have chosen to list them as your alternative contacts. We suggest you choose someone who is local and that may be available when you are not. **A renewal is necessary each year.**

**Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you,

# HEALTH CONSENT FORM 2025-2026

Please return ASAP.

# CLINTON ELEMENTARY SCHOOL



School District #32  
20397 E. Mullan Road  
P.O. Box 250  
Clinton, MT 59825-250  
(406) 825-3113 • (406) 825-3114 Fax

**A renewal is necessary each year.**

**If you are new to the school and have already completed this, another is not necessary.**

## FIRST AID

I hereby voluntarily consent to emergency treatment, first-aid examinations, and minor treatment as may be deemed necessary by school personnel. When unable to contact parent/guardian, I hereby give my permission to the school to authorize treatment needed, until the parent/guardian can be notified. If appropriate and the school is unable to contact the parent, the school may contact the medical provider listed below and follow his/her instructions. ***I am aware that the school stocks epinephrine autoinjector (EpiPen) which may be used in the event of anaphylactic emergency.***

Physician: \_\_\_\_\_

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

Dentist: \_\_\_\_\_

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

In case of an emergency involving my child AND I CANNOT BE REACHED, I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:

Preferred Hospital (in case of ambulatory transport): \_\_\_\_\_

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this form will be shared with appropriate personnel on an as-needed basis only.

Parent Signature: \_\_\_\_\_

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

## HEALTH SCREENING

I also voluntarily consent to preventive health screenings including but not limited to vision, hearing, height and weight.

Yes: \_\_\_\_\_ No: \_\_\_\_\_ Exception: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

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

Health Aide

# CLINTON ELEMENTARY SCHOOL DISTRICT

THE MCKINNEY-VENTO HOMELESS  
EDUCATION ASSISTANCE PROGRAM

Contact: Kathy Schneider, Special Services  
Director 20397 E. Mullan Rd · Clinton, MT 59825  
(406) 825-3113

## **STUDENT RESIDENCY QUESTIONNAIRE**

*Your child may be eligible for educational services through the McKinney-Vento Act.  
Eligibility is based on the current primary nighttime residence and can be determined by completing this questionnaire.*

Name of Student: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Last, First, Middle)

First Day of Enrollment: \_\_\_\_\_

**Presently, where is the student living? Check one option.**

Section A	Section B
<input type="checkbox"/> In a shelter (YWCA Women's Shelter, Union Gospel Mission, Watson's Children's Shelter, etc.)	<input type="checkbox"/> Choices in Section A do not apply
<input type="checkbox"/> Sharing housing with another family. <b>Choose one:</b>	
<input type="checkbox"/> Due to loss of housing, economic hardship, other hardship/situation or similar reason	
<input type="checkbox"/> By personal choice	
<input type="checkbox"/> In a motel, car or campsite	
<input type="checkbox"/> In Transitional Housing (YWCA Transitional Housing)	
<b>Continue → If you checked a box in Section A, please complete the rest of this form.</b>	<b><u>STOP: If you checked Section B, it is unnecessary to complete the rest of this form.</u></b>

In the past 24 months, has your child attended:  1 School  2-4 Schools  More than 4 Schools

**Student Info:** Birth date: \_\_\_\_\_ Grade: \_\_\_\_\_  
(Month/Day/Year)

Male  Female

Siblings currently enrolled/enrolling at Clinton Elementary: \_\_\_\_\_

Name of Parent(s)/Guardian(s): \_\_\_\_\_

Current Address: (City and State): \_\_\_\_\_

Phone/Message Number: \_\_\_\_\_ Alternate Phone/Cell: \_\_\_\_\_