



Rockford Public Schools Student Enrollment Request Form

School: _____

Today's Date: ___ / ___ / ___

Please Print Clearly!

Legal Name Last: _____ First: _____ Middle: _____

Have you or a sibling ever attended Rockford Public Schools? Yes No District Resident: Yes No

Home Address: _____ Confidential Address
Street: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Confidential Phone Birthdate: M/D/Y ___ / ___ / ___

Gender: Male Female Grade: _____ City of Birth: _____ Birth Certificate Required _____

Previous School: _____
Name: _____ Street: _____ City: _____ State: _____ Zip: _____

*Ethnicity: Hispanic/Latino

*Federal Race: (Please check all that apply.)

*Student's Native Language _____

Black or African American

Asian American

White

*Primary Language in Home _____

American Indian/Alaskan Native

Native Hawaiian/Pacific Islander

**State Required Information*

Is your student receiving English Language Learner services ? Yes / No If no, have they received in the past? Yes / No

Is your student receiving special education programs and/or services? Yes, please provide current documentation
 No, have they received in the past? Yes / No

Is your student receiving services under a 504 plan? Yes / No If no, have they received in the past? Yes / No

Have you ever been expelled from Rockford Public Schools or any other school? Yes / No

Primary Family/Guardian/Custodial Information (Where the student resides)

Name: _____ DoB: _____ Relationship: _____

Work: () - ext _____ Cell: () - ext _____ Other: () - ext _____

Email: _____

Name: _____ DoB: _____ Relationship: _____ Emergency Contact

Work: () - ext _____ Cell: () - ext _____ Other: () - ext _____

Email: _____

Second Family (Non-Custodial Address)

Confidential Address Confidential Phone

Name: _____ DoB: _____ Relationship: _____ Emergency Contact

Home: () - Address: _____

Work: () - ext _____ Cell: () - ext _____ Other: () - ext _____

Email: _____

Name: _____ DoB: _____ Relationship: _____ Emergency Contact

Work: () - ext _____ Cell: () - ext _____ Other: () - ext _____

Email: _____

Medical Information Medical Alert/Drug Allergies

Please use the back of this form for additional comments

Parent or Guardian Signature & Date