



Rockford Public Schools Student Enrollment Request Form

District Accredited by: AdvanceED/CA
Blue Ribbon Exemplary Schools

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