New Student ______
Returning ______

Ganado Unified School District No. 20
Ganado, AZ 86505

FOR OFFICE USE ONLY:

Grade	
Entry Date	
ID#	
Teacher	
Counselor	

Document Checklist	
IMMUN:	
Official W/:	
Trans Req:	
Birth Cert:	
Res. Affidavit	
CIB:	
Lang. Surv.	
506 Form	

SECTION A: STUDENT INFORMATION

NAME OF STUDENT ______ GENDER ______ TRIBE ______

DATE OF BIRTH ______ AGE ______ CENSUS # ______

PLACE OF BIRTH CURRENT GRADE LEVEL: ______

Is this student Hispanic/Latino? (Circle only one)	No	Yes	(A person having origins in any of the original peoples of North & South America, including Cental America, who maintains **Tribal Affiliation**)

RACE: (Choose one or more)	**Asian**	**American Indian / Alaskan Native**	**Black/ African American**	**White**	**Native Hawaiin or Pacific Islander**

PREVIOUS SCHOOL ATTENDED ______

Previous School CONTACT & PHONE # ______

STUDENT WILL: **WALK** **OR** **RIDE BUS TO:** ______

Directions to Home

Is Father / Mother in the Military? **YES** **NO**	**MARITAL STATUS: (Married, Single, etc.)**	

SECTION B: PARENT/GUARDIAN INFORMATION

PARENT / GUARDIAN #1 ______ TRIBE ______

MAILING ADDRESS ______

WORKPLACE ______ **CELL #** ______

EMAIL ADDRESS: ______ WORK # ______

PARENT / GUARDIAN #2 ______ TRIBE ______

MAILING ADDRESS ______

WORKPLACE ______ **CELL #** ______

EMAIL ADDRESS: ______ WORK # ______

***COURT or POWER OF ATTORNEY (if Child does not live with Parent)** **RELATIONSHIP TO STUDENT** ______

DOCUMENTATION PROVIDED FOR GUARDIANSHIP: ______

START & EXPIRATION DATE: ______

ANY KNOWN MEDICAL PROBLEMS, ALLERGIES, or requires GLASSES, etc:

OTHER PERSON(S) - YOU, AS PARENT, ARE AUTHORIZING THE SCHOOL TO CONTACT & RELEASE YOUR CHILD TO IN CASE OF AN EMERGENCY:

(*These individuals must be available & have valid phone number)

NAME OF CONTACT		RELATIONSHIP	
HOME ADDRESS		PHONE #	
*Please initial if allowed to checkout your child __________			

NAME OF CONTACT		RELATIONSHIP	
HOME ADDRESS		PHONE #	
*Please initial if allowed to checkout your child __________			

NAME OF CONTACT		RELATIONSHIP	
HOME ADDRESS		PHONE #	
*Please initial if allowed to checkout your child __________			

ADDITIONAL INFORMATION PARENT WOULD LIKE SCHOOL TO BE AWARE OF:

TO WHOM IT MAY CONCERN:

I, as legal parent/guardian, am responsible for this applicaton. I verify that the information I provided is true. I give my consent for any emergency medical or dental treatment.

Print Name: ____________________ Signature: ____________________

RELATIONSHIP: ____________________ WITNESS: ____________________

DATE: ____________________ DATE: ____________________

Note: It is important to fill out all possible information; this information is used for your child's safety.

5/24/2022

Office Use Only

Stamp Date Entered into SM