Plevna School District

327 North Main (PO Box 158) | Plevna, MT 59344 | (406) 772-5666

Fax (406) 772•5548 www.plevna.k12.mt.us

Student Information:

Legal First Name: ______________________________ Nickname: ______________________
Middle Name: _________________________ Last Name: ____________________________________

Birthdate: _____________ Gender: _____ SS# ________________________ Grade Level: ______

Lives with: Both Parents____ Father only____ Mother Only____ Guardian____

Ethnic Category (check one): White____ Asian or Pacific Islander_____ Native American_____
Native U.S. Virgin Islander______ Alaska Native_____
Black, not of Hispanic origin_____ Hispanic_____

Primary language spoken in the home: ____________________________________

Parental and/or Guardian Contact Information:

First Contact Name: ___________________________________ Relationship to Student: ___________
Mailing Address: ________________________________ City: ______________ State: ___ Zip: ______
Street Address: _________________________________ City: ______________ State: ___ Zip: ______
Cell Phone: _______________ Landline Phone: ________________ Work #: _____________
Email Address: _______________________________________ Employer: _________________________

Second Contact Name: ________________________________ Relationship to Student: ___________
Mailing Address: ________________________________ City: ______________ State: ___ Zip: ______
Street Address: _________________________________ City: ______________ State: ___ Zip: ______
Cell Phone: _______________ Landline Phone: ________________ Work #: _____________
Email Address: _______________________________________ Employer: _________________________

Additional Contact Name: _______________________________ Relationship to Student: ___________
Mailing Address: ________________________________ City: ______________ State: ___ Zip: ______
Street Address: _________________________________ City: ______________ State: ___ Zip: ______
Cell Phone: _______________ Landline Phone: ________________ Work #: _____________
Email Address: _______________________________________ Employer: _________________________

Emergency Contact: (if you cannot be reached):

Name: ____________________________________ Phone: __________________________

(Please fill out other side of form)

School History:

Last School Attended: ________________________________ Phone #: _________________

Address: ____ Fax #: ____________________

Date Left: ____________ Has your child ever been in Special Education classes: Yes / No

Medical Information:

Is prescription medication needed for any condition?

At Home? Yes / No Name of Medication________________________

At School? Yes / No Name of Medication________________________

Please list any health concerns or issues: ____

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imMTrax Consent Form

Please Print

Name: ____________________________ Sex: M___ F___ Date of Birth: _____________

Address: ___________________________ City: ______________ State: ___ Zip: ________

Phone #:______________________ Race: ____________ Ethnicity: ____________

Name of Parent/Guardian: ____

I authorize my health care provider and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (TIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Signature: _________________________________ Date: _________________

Primary Healthcare Provider: ____

MONTANA
Department of Public Health & Human Services
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