



O'NEILL PUBLIC SCHOOLS APPLICATION FOR STUDENT ADMISSION

ADMINISTRATIVE OFFICE · 410 E BENTON · PO Box 230 O'NEILL, NE 68763
PH 402-336-3775 · FAX 402-336-4890

- ELEMENTARY SCHOOL · 1700 N 4TH STREET · PH. 402-336-1400 · FAX 402-336-2651
 JR-SR HIGH SCHOOL · 540 E HYNES STREET · PH. 402-336-1544 · FAX 402-336-1105

Today's Date: _____

Student's Estimated Start Date: _____

Student Information			
Legal Name (First, Middle, Last)		Preferred Name	
Street Address			
City/State/Zip			
School District		If transported, distance from school	
Home Phone #		Cell Phone #	
Date of Birth		Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Social Security #		Grade	
Place of Birth		Primary Language	
Name of Previous School:		Name of Pre-School Attended:	
<input type="checkbox"/> In State <input type="checkbox"/> Out of State		(If Kindergarten Student)	
Parent/Guardian Information			
Adult #1		<input type="checkbox"/> OK to Pick Up <input type="checkbox"/> Legal Custody	
Relationship		Cell Phone #	
E-Mail Address		Military Service <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Place		Work Phone #	
Adult #2		<input type="checkbox"/> OK to Pick Up <input type="checkbox"/> Legal Custody	
Relationship		Cell Phone #	
E-Mail Address		Military Service <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Place		Work Phone #	
Parental Status			
<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single			
<input type="checkbox"/> Father Deceased <input type="checkbox"/> Father Remarried <input type="checkbox"/> Mother Deceased <input type="checkbox"/> Mother Remarried			
Primary Language			
Should there be a duplicate mailing for this child to another parent? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please complete section below for duplicate mailings: <input type="checkbox"/> Non-Custodial <input type="checkbox"/> Shared Custody			
Adult #1		<input type="checkbox"/> OK to Pick Up	
Street Address			
City/State/Zip		Home Phone #	
Relationship		Cell Phone #	
E-Mail Address			
Work Place		Work Phone #	
Adult #2		<input type="checkbox"/> OK to Pick Up	
Relationship		Cell Phone #	
E-Mail Address			
Work Place		Work Phone #	

The board supports the delivery of the education program and services to students free of discrimination on the basis of race, color, national origin, sex, disability, or marital status and provides equal access to the Boy Scouts and other designated youth groups. This concept of equal educational opportunity serves as a guide for the board and employees in making decisions relating to school district facilities, employment, selection of educational materials, equipment, curriculum, and regulations affecting students.

Emergency Contact Information - other than Parent or Guardian			
Name		<input type="checkbox"/> OK to Pick Up	
Street Address			
City/State/Zip		Home Phone #	
Relationship		Cell Phone #	
E-mail Address			
Work Place		Work Phone #	
Name		<input type="checkbox"/> OK to Pick Up	
Street Address			
City/State/Zip		Home Phone #	
Relationship		Cell Phone #	
E-Mail Address			
Work Place		Work Phone #	
Student Race and Ethnicity Information			
Part A.		Is this student (or Are you) Hispanic/Latino? <i>(Choose only one)</i>	
<input type="checkbox"/>		No, not Hispanic/Latino	
<input type="checkbox"/>		Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)	
The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your student's (or your) race to be.			
Part B.		What is the student's (or your) race? <i>(Choose one or more)</i>	
<input type="checkbox"/>		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.)	
<input type="checkbox"/>		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, and Vietnam.)	
<input type="checkbox"/>		Black or African American (A person having origins in any of the black racial groups of Africa.)	
<input type="checkbox"/>		Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)	
<input type="checkbox"/>		White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)	
Additional Student Information			
Has this child received Special Education Services?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, is there a current IEP, MDT?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this child a ward of the State or Court?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has this child been expelled from school (either public or private in any state)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, has the term (time period) of expulsion been completed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this child homeless?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this child migrant?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this child a single parent?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Health Questions (If you answer yes to any of the questions, please explain.)		
Is your child allergic to any medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your child have any food allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, does your child use an epi pen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please contact the School Nurse to complete an action plan.		
Does your child have any other allergies or sensitivities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, does your child use an epi pen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please contact the School Nurse to complete an action plan.		
Does your child have any asthma or breathing difficulties?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, does your child use an inhaler?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, how often?		
* Students with asthma or severe breathing difficulties must contact the School Nurse to complete an action plan.		
Is your child diabetic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, does your child use insulin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, what type, dose, and time?		
* Students with diabetes must contact the School Nurse to complete an action plan.		
Has your child ever had a seizure or convulsion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please contact the School Nurse to complete an action plan.		
Does your child have any cardiac/heart conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child been diagnosed with any chronic disease or condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your child have any hearing problems or frequent infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your child require any special equipment/medical supplies such as hearing aids, nebulizers, peak flow meter, glucose monitors, etc?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your child take any prescription medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please list names and doses of all medications.		
If yes, will any of these medications be administered at school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please contact the school nurse to complete appropriate forms.		
Does your child take any over the counter medications routinely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child had any surgical procedures or operations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child had the varicella (chicken pox) disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, what year?		
Does your child have any psychiatric, behavioral, or emotional concerns?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please lists any other medical concerns:		
Can the above information be shared with staff members that work with your child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>I verify that the above information is correct to the best of my knowledge.</i>		

Parent Signature _____ Date _____

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Please respond
in English

Nebraska Department of Education
Home Language Survey

English
Home Language Survey

Date: _____ Grade: _____

Student's Name: _____

Parent or Guardian's Name: _____

Address: _____

City/State/Zip: _____

Home Phone #: _____ Work Phone #: _____

Is this student's first-learned or home language anything other than English? Yes No

If yes, please respond to the following questions:

What is the student's country of origin? _____

Which language did this student learn when he/she first began to talk? _____

What language does this student most frequently use at home? _____

What language does the mother most frequently speak to this student? _____

What language does the father most frequently speak to this student? _____

What is the language most frequently spoken at home? _____

Please describe the language understood by your child. **(Check only one)**

- Understands only the home language and no English.
- Understands mostly the home language and some English.
- Understands the home language and English equally.
- Understands mostly English and some of the home language.
- Understands only English.

If available, in what language would you prefer to receive communication from the school? _____

Parent or Guardian's Signature

Date