		Enro	Ilment Form fo	r Fowler	Jr/Sr High					
First Name:	Middle:			Last Name:	Last Name:					
Preferred Name:	Grade:			Birth Place: DOB:				:		
Race: Amer.	Asian Black or A	frican Americ	can Native Haw	aiian/Pac Islande	er	White	(underline)			
Hispanic/Latino? Yes No	Gender:			Home Lang.:						
Access Internet?	Cell #			Email:						
PRIMARY HOUSEHOLD (ST				•						
Mailing:				Street:						
City:	State:	Zip:		City:		State:		Zip:		
Information for adults living Name:	at the above a		dress. Relationship:							
Work #		Cell #	ыпр. ————————————————————————————————————		Employer: POL Account:	l Dod	anius D	winted Me	ilin ann	
Email:			1.		Home #	Rec	ceive P	rinted Ma	ilings:	
Name:		Wk Email:			Employer:					
	Relationship: Cell #									
Work #						Red	Receive Printed Mailings:			
Email:	(NON CUSTODI	Wk Email:			Home #					
ALTERNATE HOUSEHOLD Mailing:	(NON CUSTODI	AL)		Street:						
City:	Zip: City:			State: Zip:						
Information for adults living	State:			low).		Totalo.				
Name:	,	Relations	ship:		Employer:					
Work #		Cell #			POL Account:	Red	ceive P	rinted Ma	ilings:	
Email:	Wk Email:			Home #						
Name:	Relationship:			Employer:						
Work #		Cell #			POL Account:	Red	ceive P	rinted Ma	ilings:	
Email:		Wk Emai	l:		Home #	<u> </u>				
ALTERNATE HOUSEHOLD	(NON CUSTODI									
Mailing:	•	•		Street:						
City:	State:	Zip:		City:		State:		Zip:		
Information for adults living	at the above a			•	_	•				
Name:		Relations	ship:		Employer:					
Work #		Cell #			POL Account:	Red	ceive P	rinted Ma	ilings:	
Email:		Wk Emai			Home #					
Name:		Relations	ship:		Employer:					
Work #		Cell #			POL Account:	Red	ceive P	rinted Ma	ilings:	
Email:	Wk Email:			Home #						
EMERGENCY CONTACTS: Enter additional contacts not listed above. Name: Relationship: Email:										
Home #		Work #	siiip.		Cell #					
Name:			ah in .							
		Relationship:			Email:					
Home #		Work # Relationship:			Cell #					
Name:			snip:		Email:					
Home #	ati a m	Work #			Cell #					
Emergency Medical Information Physician:	ation	Phone:			Hospital:					
Medical Notes:		i none.			Tiospitai.					
Daycare Information (if app	licable)				Disarra					
Provider:	Phone:	Filone.								
SIBLINGS (other students living at same ac First Name Middle Name		Last Name		G	Grade	Birthdate	thdate School Name		e	
Completed By:			Signature:			Date	a:			
			J.g.iature			Date	· —			