MARSS#:_____ Transcript:_____ Health Records:_____ IEP/504:_____ For Office Use Only	**Kenyon-Wanamingo Schools** **District # 2172** **Registration Form**	Enrollment Date: _____ Bus Required:_____Yes _____No 1st Language Used by student_____ Home Language:_____ Migrant: _____Yes _____No For Office Use Only

Today's Date: _____

STUDENT'S (LEGAL) NAME: _____ _____ _____
Last First Middle

Known as: (Nickname) _____

Gender: M F Date of Birth:_____ Grade:_____

Student Lives With: _____Both Parents _____Mother Only _____Father Only _____Mother/Stepfather
_____Father/Stepmother _____Foster Parent* _____Guardian* _____Other

*If other than parents:_____ _____ _____
Name & Relationship Employer Work Phone

Guardianship documentation: _____Yes _____No Date Received:_____

Email Address:_____ Cell Phone:_____

LEGAL MOTHER OF STUDENT: Mother Living: _____Yes _____No Legal Rights: _____Yes _____No

Full Name:_____ _____ _____ _____
Last First Middle Home Phone

Address _____ _____ _____ _____
Street City State Zip

Email Address: _____ _____
Cell Phone

Employer/Phone:_____

LEGAL FATHER OF STUDENT: Father Living: _____Yes _____No Legal Rights: _____Yes _____No

Full Name:_____ _____ _____ _____
Last First Middle Home Phone

Address (*if different*) _____ _____ _____ _____
Street City State Zip

Email Address: _____ _____
Cell Phone

Employer/Phone:_____

EMERGENCY CONTACT & Phone, if parents cannot be reached:_____

Relationship to Student:_____

PREVIOUS SCHOOL NAME:_____District #:_____

School Phone Number:_____ Date Last Attended:_____

Please list, in order of all children in the family (including student listed above)

Last Name	First	Middle	Gender	Birth Date	School	Grade

STUDENT SUPPORT SERVICES INFORMATION:

1) Does your child receive special accommodations at school for a disability (504 Plan)? _____Yes _____No

2) Does your child have an IEP? _____Yes _____No

If yes, please check student's primary disability.

___Autism Spectrum Disorders ___Deaf & Hard of Hearing ___Developmental Cognitive Disability (Mild)
___Emotional-Behavioral Disorder ___Traumatic Brain Disorder ___Developmental Cognitive Disability (Severe)
___Physical Impairment ___Other Health Disorder ___Specific Learning Disability
___Visual Impairment ___Speech Language Impairment

3) Please choose which of the following situations the student currently resides in (you can choose more that one):
___House or Apartment with parent or guardian
___Motel, car or campsite
___With friends or family members (other than in addition to parent/guardian)
___Shelter or other temporary housing

4) If you are living in shared housing, please check all of the following reasons that apply:
___Loss of housing ___Economic situation ___Temporarily waiting for house or apartment
___Loss of employment ___Provide care for a family member ___Living with boyfriend/girlfriend
___Parent/Guardian is deployed ___Other (Please explain):_____

5) Are you a student under the age of 18 and living apart from your parents or guardians? ___Yes ___No
6) In the past three years, has anyone in your household had a job working with livestock, crops, processing agriculture products, or other agriculture? ___Yes ___No

MEDICATION

THE "SCHOOL MEDICATION PHYSICIAN ORDER AND PARENT AUTHORIZATION" FORM WITH THE DOCTOR'S SIGNATURE AND PARENT'S SIGNATURE IS REQUIRED FOR ALL PRESCRIPTION MEDICATIONS TAKEN ON SCHOOL PROPERTY. OVER-THE COUNTER MEDICATIONS (SUCH AS TYLENOL OR IBUPROFEN) IN ORIGINAL BOTTLE, WILL ONLY BE ALLOWED AFTER A PARENT AUTHORIZATION FORM IS ON FILE AT SCHOOL. THE SCHOOL DOES NOT SUPPLY ANY OVER-THE-COUNTER MEDICATIONS FOR THE STUDENTS. THIS FORM MUST BE DONE EACH SCHOOL YEAR FOR ALL MEDICATIONS. SEE THE OFFICE FOR FORMS OR THE SCHOOL NURSE FOR QUESTIONS AT 789-6186 EXT. 7011.

Medications:_____

In the event parents or other persons named on this form cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of afore said child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

_____ _____

Signature of Parent or Guardian Date