

MARSS#: _____ Transcript: _____ Health Records: _____ IEP/504: _____ For Office Use Only	Kenyon-Wanamingo Schools District # 2172 Registration Form	Enrollment Date: _____ Bus Required: _____ Yes _____ No 1 st 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:

Does your child have an IEP? Yes No

If yes, please check student's primary disability.

- | | |
|--|--|
| <input type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Deaf & Hard of Hearing |
| <input type="checkbox"/> Developmental Cognitive Disability (Mild) | <input type="checkbox"/> Developmental Cognitive Disability (Severe) |
| <input type="checkbox"/> Emotional-Behavioral Disorder | <input type="checkbox"/> Other Health Disorder |
| <input type="checkbox"/> Physical Impairment | <input type="checkbox"/> Specific Learning Disability |
| <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Traumatic Brain Disorder |
| <input type="checkbox"/> Speech Language Impairment | |

Does your child receive special accommodations at school for a disability (504 Plan)? Yes No

“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. 789-6186 EXT. 7011 or 827-2211 EXT. 2225 AT THE ELEMENTARY.

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