MONTICELLO SCHOOL DISTRICT 4K REGISTRATION INFORMATION

Student Last Name: ________________ First Name: ______________ Middle: ________

Date of Birth: ______________ Place of Birth: ________________ [ ] Male [ ] Female

Student lives with: [ ]Father [ ]Mother [ ]Stepmother [ ]Stepmother [ ]Other:________

Ethnic Code (check all that apply): [ ] White [ ] Black or African American

[ ] Hispanic/Latino [ ] Asian or Pacific Islander [ ] American Indian/Alaska Native

PARENT/GUARDIAN INFORMATION-PRIMARY RESIDENCE:	
Parent/Guardian 1:	Parent/Guardian 2:
Home Address:	Home Address:
Home Phone: Cell:	Home Phone: Cell:
E-mail Address:	E-mail Address:
Employer & Hours:	Employer & Hours:
Work Phone:	Work Phone:
Legal Custody: Y/N Shared Custody: Y/N	Legal Custody: Y/N Shared Custody: Y/N
[ ] Married [ ] Single [ ] Separated [ ] Divorced	[ ] Married [ ] Single [ ] Separated [ ] Divorced

PARENT/GUARDIAN INFORMATION-SECONDARY RESIDENCE:	
Parent/Guardian 1:	Parent/Guardian 2:
Home Address:	Home Address:
Home Phone: Cell:	Home Phone: Cell:
E-mail Address:	E-mail Address:
Employer & Hours:	Employer & Hours:
Work Phone:	Work Phone:
Legal Custody: Y/N Shared Custody: Y/N	Legal Custody: Y/N Shared Custody: Y/N
[ ] Married [ ] Single [ ] Separated [ ] Divorced	[ ] Married [ ] Single [ ] Separated [ ] Divorced

LOCAL PERSONS TO BE CALLED IN AN EMERGENCY:			
First Name	Last Name	Relationship	Daytime Phone Number

EMERGENCY PHYSICIAN AND DENTIST TO BE CALLED IN CASE OF AN ACCIDENT:	
Physician:	Dentist:
Address:	Address:
Phone Number:	Phone Number:

HEALTH CONCERNS:
Does your child have any special health concerns? [ ] Asthma [ ] Diabetes
[ ] Seizure Disorder [ ] Severe Allergy [ ] Other ______________________________
Is your child currently taking medication? [ ] Yes [ ] No Name of medication: ____
Has this child received immunizations? [ ] Yes [ ] No Please provide the school with copies of the immunization record before school begins

IF YOUR CHILD REQUIRES ANY MEDICATION DURING SCHOOL HOURS, PLEASE COMPLETE THE MEDICAL AUTHORIZATION FORM

Please describe any physical or emotional condition your child has that may require special attention while he/she is in school attendance. This information will be shared with school staff having a direct need to know so they may modify the classroom or protect the health and safety of your child. Note: include any food or other allergies as well as pertinent medical information.

SPECIAL NEEDS:
Does the student currently receive "special education" services? [ ] Yes [ ] No
Has the student been evaluated for "special education" services? [ ] Yes [ ] No
Does the student currently receive "504 accommodations"? [ ] Yes [ ] No
Does the student currently receive any other special services? [ ] Yes [ ] No

IDENTIFY ALL OF THE FOLLOWING WHICH APPLY TO YOUR CHILD:
[ ] Stays at home with parent
[ ] Attends a daycare-if yes, which daycare? ______________________________

IF YOUR CHILD WILL REQUIRE TRANSPORTATION NEXT YEAR, PLEASE COMPLETE THE SPECIAL BUS SERVICE REQUEST FORM

Is this child's primary home language English? [ ] Yes [ ] No
If no, please specify the home primary language. ______________________

Is this student open enrolled? [ ] Yes [ ] No
If yes, what district do you reside in? ______________________

Does this child have siblings enrolled in Monticello School? [ ] Yes [ ] No

CHILDREN IN HOUSEHOLD
(Please list ALL other children in the household)

[ ] **No Additional Children** (If additional children in household, please continue below.

Primary Household Siblings:

Legal Last Name:	First Name:	Middle Name:	Gender:	Date of Birth: mm/dd/yyyy	Grade:

Secondary Household Siblings:

Legal Last Name:	First Name:	Middle Name:	Gender:	Date of Birth: mm/dd/yyyy	Grade:

Is there any other information about your child you would like to share? ______________

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