

St. Libory Consolidated School District #30

2024-2025 Registration Form

STUDENT DATA:

Last Name: _____ First Name: _____ Middle Name: _____

Physical Address: _____

Mailing Address (if different from Physical Address – PO BOX): _____

Grade Level: _____ Gender: ☐ M or ☐ F Birthdate: _____ Place of Birth: _____

Parent e-mail addresses for **TeacherEase**. This is our main form of communication with parents:

Please list phone numbers and names for text messaging and phone call alerts: _____

Student lives with (check one) ☐ Both Parents ☐ Mother ☐ Father ☐ Mother/Stepfather ☐ Father/Stepmother

☐ Guardian* ☐ Other* *Please indicate the relationship to the student _____

If a student does not reside with both custodial parents, duplicate records can be emailed to the non-residential parent upon request.

Non-residential parent name and address: _____

PARENT CONTACT DATA (Mother, Father, and/or Guardian-Parents are contacted in this order):

1st _____ Relationship _____

Address: _____ Cell # _____ Home # _____

Employed at _____ Work # _____

2nd _____ Relationship _____

Address: _____ Cell# _____ Home# _____

Employed at _____ Work # _____

Additional Emergency Contact Information (Parental contacts will be notified first. List additional contacts in priority order)

3 rd Name: _____	Relationship _____	Home Phone _____	Cell Phone _____
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4 th Name: _____	Relationship _____	Home Phone _____	Cell Phone _____
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5 th Name: _____	Relationship _____	Home Phone _____	Cell Phone _____
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Race (Please check ONLY one) ☐ Hispanic ☐ Asian ☐ African American ☐ White ☐ American Indian

☐ Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Multiracial

Do you live within 1.5 miles of the school? ☐ YES or ☐ NO

How is your student transported to and from school? (check one) ☐ Bus ☐ Walk ☐ Parent Transport ☐ Daycare Transport

What is the primary language spoken in the home? _____

Does anyone in your home speak a language other than English? ☐ YES or ☐ NO What language? _____

Does your son/daughter speak a language other than English? ☐ YES or ☐ NO What language? _____

Name of last school attended: _____

Has the child been in any special classes? (check one) ☐ LD ☐ EMH ☐ SPEECH ☐ TITLE I

☐ SPECIAL EDUCATION

Has your child ever repeated a grade? ☐ YES or ☐ NO If yes, what grade was repeated? _____

Military Family Information

1. Does the child's parent or guardian serve in the military, including National Guard or Reserve? ☐ YES or ☐ NO
2. Is the parent or guardian currently serving on active duty or expects to be deployed this year? ☐ YES or ☐ NO
3. Have a parent or guardian returned from deployment in the last 6 months? ☐ YES or ☐ NO

The Illinois State Board of Education requires that the birth certificate of each student be kept on file at the school.

If you are a returning student, we should already have a birth certificate on file.

However, you will be notified at registration if we are in need of one.

You will not be able to register your child for the upcoming school year until a birth certificate is on file in the office.

☐ YES or ☐ NO: The district has my permission to allow the media to use my child's picture and/or place my child's picture on the internet(social media) and/or in newspapers for special recognition

☐ YES or ☐ NO: I hereby give my student permission to use the internet based on the school policy.

☐ YES or ☐ NO: I have reviewed and understand that my student is subject to all provisions of the rules and regulations contained in the parent-student handbook. The parent-student handbook can be found on the school website.

My child has permission to watch G ☐ - PG ☐ - PG13 ☐ movies at St. Libory School.

☐ YES or ☐ NO: I give my child permission to attend any and all school field trips during the school year.

I verify that all of the information provided on this form is true and accurate to the best of my knowledge. My child is a legal resident of St. Libory CSD 30, residing within the boundary lines of said district, and mandated by the Illinois State Board of Education.

Signature of Custodial Parent or Guardian

Date

OFFICE USE ONLY

Residency Verification

Birth Certificate

Health Questionnaire

Health Forms V D P SP

Medication Policy Form

Custodial Papers

IL SIS # _____

Health Questionnaire

Please complete the following questions regarding your child. This information is being requested so the school can provide your child with the best possible learning environment. Information provided will be shared with classroom teachers and/or other individuals only as deemed necessary by the administration.

Student Name _____ Grade _____

**Please check box to indicate student has health concern
and explain further in space provided:**

- ☐ Vision problem - _____
☐ Wears glasses ☐ wears contacts
If you child wears glasses, when are they to be worn?
☐ near work ☐ far work ☐ at all times ☐ may be removed for recess/PE
- ☐ Hearing problem - ☐ left ear ☐ right ear ☐ both ears
- ☐ Migraines
- ☐ Seizure disorder – Please describe type of seizure and frequency of occurrence.

- ☐ Heart problems - _____
- ☐ Respiratory problems - _____
☐ asthma ☐ reactive airway disease (RAD) ☐ other _____
- ☐ Muscular-skeletal problem - _____
- ☐ Stomach or digestive problems - _____
- ☐ Urinary problems - _____
- ☐ Bowel problems - _____
- ☐ Physical limitations or restrictions (Physician's note required for PE/recess modifications or exclusions lasting more than 3 days) _____

- ☐ Attention Deficit / Hyperactivity Disorder (AD/HD)
- ☐ Mental Health Condition - ☐ depression ☐ bipolar ☐ anxiety disorder ☐ other
- ☐ Allergies - ☐ food ☐ medication ☐ environmental ☐ latex ☐ other
(please describe) _____

Current routine medications (please list) **Any medication that needs to be given by school personnel (prescription and over-the-counter) MUST be accompanied by a physician's medication order form. Forms available in the school office.**

Medication _____

Dosage _____

Time Taken _____

Please use this space to provide additional information regarding any health concern or health condition.

Please complete the following information for emergency purposes:

Family Physician or Pediatrician Name _____

Phone _____

Dentist Name _____

Phone _____

In case my child needs emergency medical care, transport him/her to the nearest hospital. I agree to assume all responsibility and expense, including transportation costs. I authorize the attending physician and hospital to render medical care to my child as necessary. I understand that Illinois law requires ambulances transport to the nearest hospital to insure the patient is stable before transporting to another facility.

Signature of Parent or Legal Guardian

Date

Attention Parent or Legal Guardian: If you have any questions, or if you feel any of the information requested is of a sensitive or confidential nature, please contact the superintendent for a private conference.