REGISTRATION INFORMATION

Student Basic Info
First Name:
Middle Name:
Last Name:
Gender: (circle one) Male Female
Birth Date:
Phone:
Grade Level: 9 10 11 12

Student Mailing Address
Addr 1:
Add 2:
Add 3:
City:
State:
ZIP:

Student Physical Address (if different)
Addr 1:
Addr 2:
Addr 3:
City:
State:
ZIP:

Contact 1 (Parent/Guardian)

Title: (circle one) Mr. Mrs. Ms.	Name:
Address1:	Home Phone:
Address 2:	Work Phone
City: Zip:	Cell Phone:
Email:	Other Phone:

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Contact 2 (Parent/Guardian)

Title: (circle one) Mr. Mrs. Ms.	Name:
Address1:	Home Phone:
Address 2:	Work Phone
City: Zip:	Cell Phone:
Email:	Other Phone:

Home School Information	
Previous School District #:	
Student District Representative Contact Name:	
Student District Representative Contact Phone:	

Medical Notes:

Diagnosis: Medication:	
Privately Enrolled:	**YES NO**
Permission to give Ibuprofen:	**YES NO**
Asthma:	**YES NO**
Allergies	**YES NO**
Seizures:	**YES NO**

If known, please answer the following:

Occupational Therapy Minutes Per Week:	
Speech Therapy Minutes Per Week:	
Social Work Minutes Per Week:	