

SCHOOL DISTRICT OF PLATTEVILLE REGISTRATION FORM

Grade _____ School: Neal Wilkins Westview Middle School High School

Previous School Attended: _____ Public Private

Previous School's Address: _____

Note: Please print full, legal name (as appears on birth certificate)

Student's Name _____
(First) (Middle) (Last)

Name Child Prefers (if different than above - ex. "Bob" instead of "Robert") _____

Home Address _____

City _____ State _____ Zip _____ County _____

Township _____ Primary Phone _____ Land Line Cell Phone

Date of Birth _____ Age _____ Male Female

Student's Birth City _____ Student's Birth State _____

**If Student born outside of United States, list country of birth _____

Student's Ethnicity and Race: To comply with Federal requirements: Complete both parts 1 and 2

Part 1 - Ethnicity (check only one) Hispanic or Latino Not Hispanic or Latino

Part 2 - Race (check all that apply, but check at least one)
 Asian Black or African American
 American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander
 White

Parents/Guardians with whom the child resides:

Name _____ Work Phone _____

Employer _____ Cell Phone _____

Email Address _____

Relationship to Child: Father Stepfather Orion House
 Mother Stepmother Independent
 Guardian Foster Parent Other

Name _____ Work Phone _____

Employer _____ Cell Phone _____

Email Address _____

Relationship to Child: Father Stepfather Orion House
 Mother Stepmother Independent
 Guardian Foster Parent Other

Parent/Guardian that resides at a different address: Joint Custody Non-Custodial

Name _____ Phone _____ Land Line Cell Phone

Address _____ City, State, Zip _____

Email Address _____

Relationship to child: Father Mother Guardian

Please fill in reverse side

Should the Parent/Guardian receive report cards? Yes No

Revised 11-11-11 SK

Family Information - Please list **all** school-aged children in your family. We are required to research on suspected handicapped children ages 0-21.

Name	Date of Birth Mo, Day, Yr	Gender M F	School of Attendance	Grade	Handicapping Condition Suspected

Child Care Provider Information: (for Middle School and Elementary Students)

Will your child be at child care? Yes No Before school After school

Name of child care provider _____ Phone: _____

Address: _____

Has this student attended the School District of Platteville in the past? Yes No

Has this student ever been expelled from another school? Yes No

For PHS driving students only:

License Plate Number: _____

Model/Make _____ Color _____ Year _____

OFFICE USE ONLY:

Date of Enrollment _____ Birth Certificate Verified: _____ Other ID _____

Homeroom/Advisor _____ Entered in Skyward: Date _____ By _____

Fees paid: Date _____ Amount \$ _____ Received by _____

STUDENT HEALTH INFORMATION

Student's Name _____ DOB _____ School _____ Grade _____

Emergency Call Numbers:

If a parent or guardian is not available, whom else may we call for help? Please list a primary and secondary number of two other individuals that we can call:

Name 1:	Name 2:
Primary Phone:	Primary Phone:
<input type="checkbox"/> Land Line <input type="checkbox"/> Cell Phone	<input type="checkbox"/> Land Line <input type="checkbox"/> Cell Phone
Secondary Phone:	Secondary Phone:
<input type="checkbox"/> Land Line <input type="checkbox"/> Cell Phone	<input type="checkbox"/> Land Line <input type="checkbox"/> Cell Phone
Relationship to Child:	Relationship to Child:

1. Please list any health condition that could require special care in an emergency situation and describe what needs to be done to protect the health of your child. This information will be available to school staff. If your child has health concerns that you prefer to keep confidential, please contact Mary Klarer Logemann, School Nurse at 342-4013.

Health Condition	Action Needed

List Allergies _____

2. Is there any other information about your family that the school needs to know? Please explain:

3. Please indicate any significant illness, surgery and/or injury your child has had and at what age.

4. Please list below the physician you would prefer we call in the event you cannot be reached.

Physician _____ Phone Number _____

Hospital Preference _____ Phone Number _____

Name of Family Health Insurance Co _____

Health Insurance Group Number _____

5. If your child wears glasses, date of last exam: _____

Describe reason for wearing glasses:

Near Vision _____ Far Vision _____ Stigmatism _____ Other _____

6. Are there any concerns about your child's developmental progress?

Date _____

Parent/Guardian Signature _____