

Lomira School District Student Registration

STUDENT LEGAL NAME: _____
Last First Middle

DATE OF BIRTH: _____ **SEX:** ___ Male ___ Female **GRADE ENTERING:** _____

BRITH CERTIFICATE VERIFIED: _____ **BIRTH CITY:** _____ **BIRTH STATE:** _____

STUDENT LIVES WITH: ___ Both Parents ___ Father ___ Mother Other: _____

STUDENT LIVES IN: ___ HOUSEHOLD #1 ___ HOUSEHOLD #2

INFORMATION ON HOUSEHOLD #1:

ADDRESS: _____	PRIMARY PHONE _____
Street Address	P.O. Box: _____
_____	_____
City	Zip
Father's Name: _____	Cell Phone: _____
Father's Employer: _____	Work Phone: _____
Mother's Name: _____	Cell Phone: _____
Mother's Employer: _____	Work Phone:: _____
Email: _____	

INFORMATION ON HOUSEHOLD #2: (IF APPLICABLE)

ADDRESS: _____	PRIMARY PHONE _____
Street Address	

City	Zip
Father's Name: _____	Cell Phone: _____
Father's Employer: _____	Work Phone: _____
Mother's Name: _____	Cell Phone: _____
Mother's Employer: _____	Work Phone: _____
Email: _____	

SCHOOL LAST ATTENDED: (address & phone) _____

Has the above student ever been expelled: ___yes ___no

FEDERAL RACE/ETHNICITY: Is your child Hispanic or Latino? ___Yes ___No

What is your child's race: ___American Indian or Alaska Native ___Asian ___Black or African American
___Native Hawaiian or Other Pacific Islander ___White

EMERGENCY CONTACT:

If parents cannot be reached immediately, who should be contacted? These people may take my child from school in an emergency situation:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Please list all children who are living in the SAME household under the age of 21:

Full Name	Birthdate	Age	Gender	Grade	School Attending

SPECIAL PROGRAMMING: Please check the area(s) that apply to your child.

Title 1 Reading Section 504 Plan RTI Child Study Plan
 Title 1 Math Gifted and Talented After School Program

SPECIAL EDUCATION: Please check the area(s) that apply to your child.

Speech/Language Impairment Significant Developmental Delay Autism
 Specific Learning Disability Visual Impairment Other Health Impairment
 Cognitive Disability Hearing Impairment Traumatic Brain Injury
 Emotional/Behavioral Disability Orthopedic Impairment

List any additional services that your child has received in her/his previous school:

Please list any unusual health conditions of the student or medications:

BUSING NEEDED: yes no (If yes, complete transportation form.)

Parent Signature
 Father Mother Legal Guardian

Date