Entering Grade ____
Student ID # _____
Youngest and/or only child in District 113A YES NO

LEMONT-BROMBEREK COMBINED SCHOOL DISTRICT 113A
STUDENT REGISTRATION FORM

Student's Name_____ **Native Language**_____**Gender: M - F**
Last First Middle

Address _____
Street (Including "Street," "Drive," etc.) City Zip Code

Home Phone (Area Code)_____/_____ **e-mail address** _____

Birth Date_____ **City**_____ **State** _____ **Country** _____

School Previously Attended _____ **School Phone (Area Code)**_____/_____

School Address _____

Residency Statement: I attest to the fact that the parent/guardian **and** the above named student are legal residents of District 113A and will provide proof of residency as required by the District.

Parent/Guardian Signature _____ **Date** _____

Mother's Name _____
Last First Maiden

Mother's Birthplace _____ **Cell Phone (Area Code)**_____/_____

Mother's Employer _____ **Phone (Area Code)**_____/_____

Address _____

Father's Name _____ **Cell Phone (Area Code)**_____/_____
Last First

Father's Birthplace _____

Father's Employer _____**Phone (Area Code)**_____/_____

Address _____

Age(s) of **Brother(s)** _____ **Sister(s)** _____

Parent/Guardian Status ☐Married ☐Divorced ☐Other
If divorced, indicate any restrictions on release of the child to the non-custodial parent, as authorized in an Order of Protection, a legible copy of which must be attached to this enrollment form. (NOTE: A divorce decree is ***NOT*** an Order of Protection.)

_____

Special Health Conditions (list allergies, medications, disabilities, etc.; attach additional page, if necessary)

_____

Student's Physician_____ **Phone (Area Code)**_____/_____
Physician's Hospital Affiliation_____

Medical Authorization: In the event reasonable attempts to contact the parent/s at the locations listed above are unsuccessful, I/we, as parent/s or legal guardian/s of the above student, do hereby authorize: (1) the treatment by a licensed medical physician of my child/ward in the event of a medical emergency, which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed; and (2) the transfer of my child/ward to any hospital reasonably accessible. This release is completed and signed with the purpose of authorizing medical treatment under emergency circumstances in my absence.
Parent/Guardian Signature _____ **Date** _____

Emergency Contact: In case of emergency or illness, when parents/guardians cannot be reached, please indicate someone school personnel could attempt to call who would be able to come for your child. (Local phone please---neighbors or relatives living in the area.)

1. **Name**_____ **Phone** (**Area Code)**_____/_____
2. **Name**_____ **Phone** (**Area Code)**_____/_____