



Carmi-White County PreK Enrollment Form

Student's Name: _____ Grade: _____
Last Middle First Suffix

Primary Phone: _____ Cell Phone: _____ Male _____ Female _____

Date of Birth: _____ Place of Birth: _____ SSN: _____

Home Address: _____
Street Address City State Zip

Race: *Please check all applicable:*

- White Black or African American Asian American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander

Parents/Guardians 1: *List parents/guardians living with student (i.e., mom & dad or mom & stepdad)*

Name 1: _____	Name 2: _____
Cell#1: _____	Cell# 2: _____
Workplace: _____	Workplace: _____
Work#2: _____	Work# 2: _____
Email: _____	Email: _____
Address: _____	
Relationship to student _____	<i>(mom & dad, mom& stepdad, etc)</i>

Is there anyone, by court order, who is not allowed to pick up this student? If so, who?*

** The school must have legal documents on hand in order to enforce if the person listed is a parent*

Parents/Guardians 2: *(Other Parent Household, if applicable)*

Name 1: _____	Name 2: _____
Cell#1: _____	Cell# 2: _____
Workplace: _____	Workplace: _____
Work#2: _____	Work# 2: _____
Email: _____	Email: _____
Address: _____	
Relationship to student _____	<i>(mom & dad, mom& stepdad, etc)</i>

Does your child have an IEP?

Yes

No

Please complete the following regarding your child's current living situation:

- Are you and your child living with relatives or others? Yes No
- Are you or your child living in a motel/shelter/campground? Yes No
- Is your gas, electric or water currently turned off? Yes No
- Are you a student not currently living with your parent? Yes No
- If you answered yes, does the person you are living with have a court ordered guardianship or have you been adopted? Yes No
- Are you in foster care? Yes No

Please list emergency contacts other than parents. Include additional contact numbers on a separate sheet, if needed.

Emergency Contact 1: _____ Relationship: _____ Phone: _____

Emergency Contact 2: _____ Relationship: _____ Phone: _____

Does this student have school-aged brothers and sisters living in the same household? If so, please list their names and schools they attend. (If more space is needed, please use a separate piece of paper.)

CARMI-WHITE COUNTY PREK C.U.S.D. NO. 5

Parental Authorization for 2018-2019

Student: _____ School: _____ Grade: _____

Field Trip Authorization – My child has my permission to go with his/her class on any field trips the class might take during school hours. Should any emergency arise, and in the event reasonable attempts to contact me at the telephone numbers listed below are unsuccessful, I hereby give my consent for the administration of emergency medical treatment to my child.

Home Phone: _____ Cell Phone: _____ Work: _____

Name of Doctor: _____ Doctor's Phone: _____

Permission to Publish on the Internet – I hereby give permission for my photograph, picture, and/or project to be published on the Internet. I understand that my last name will not be used with the published photograph, picture or project.

(Please Initial) _____ Yes _____ No

Parent Involvement - I hereby give permission to be contacted by class or extracurricular sponsors for the purposes of volunteering for various activities.

(Please Initial) _____ Yes _____ No

School Messaging Service (For Weather Related School Cancellations and School Notifications)

Primary Phone

Primary Email

Secondary Phone

Secondary Email

Parental Insurance Waiver – As a service to students and their families, a student accident insurance plan and/or dental plan is being made available for your child at a very nominal cost through Gerber Life Insurance Co.

REASONS TO PURCHASE THIS COVERAGE:

1. Deductible and co-pays in your health plan. Many health plans have increased the amount of out-of-pocket expenses. This plan will provide benefits for medical expenses incurred because of an accident. If you have other insurance, benefits can be applied to your deductible or co-pays.
2. No other insurance. If you have no other insurance, this will become your primary accident plan.

If you want to purchase coverage, student insurance applications are available online at www.k12specialmarkets.com or you can obtain an application from the school office.

If you already have adequate insurance, please initial below.

_____ I hereby acknowledge that I have adequate insurance to protect my son/daughter in the case of an accident and waive the accidental coverage. (Please Initial)

Date: _____

Parent/Guardian Signature _____

Student Signature: _____

CARM-WHITE COUNTY C.U.S.D. #5
ANNUAL HEALTH INFORMATION FORM

Student's Last Name	First Name	Date of Birth	Grade Level
Physician's Name			

Check (✓) the box if your child has no history of medical problems, illness, or allergies and complete signature below.
 No history of medical problems, illness or allergies. Immunization Exempt Yes No May share with IDPH Yes No

Check (✓) the box(es) if your child has a history of any medical problems &/or illness.

Asthma: Triggered by: _____ Uses inhaler Yes No Uses Nebulizer Yes No
 Severity: Mild/Intermittent Moderate Severe

Seizures: Date of last: _____ Has your child been prescribed Diastat? Yes No
 Type: Grand Mal Petit Mal Partial Complex

Diabetes: Age Diagnosed: _____ Requires Carb Counting Yes No Takes Insulin Yes No

A plan of care must be in place – contact the district nurse.

Frequent Ear Infection: Tubes Yes No
Hearing Problems: Hearing Aids Yes No
Vision Problems: Wears Glasses Yes No Wears Contacts Yes No
Skin Disorders: Eczema Psoriasis Other: _____
Has your child had chicken pox: Yes No

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> In counseling: List physician's name and diagnosis _____	
<input type="checkbox"/> Anxiety/Panic/Emotional Disorder	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Speech Problems
<input type="checkbox"/> Autism / Aspergers	<input type="checkbox"/> Frequent Strep Throat	<input type="checkbox"/> Stomach / Bowel Disorders
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Braces / Dental Appliances	<input type="checkbox"/> Kidney / Urinary Disorders	

Check (✓) the box(es) if your child has a history of any allergies.

Allergy:	Please List:	Reaction:	
<input type="checkbox"/> Latex	_____	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Rash <input type="checkbox"/> Other: _____
<input type="checkbox"/> Medication	_____	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Rash <input type="checkbox"/> Other: _____
<input type="checkbox"/> Foods	_____	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Rash <input type="checkbox"/> Other: _____
<input type="checkbox"/> Insect Stings	_____	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Rash <input type="checkbox"/> Other: _____
<input type="checkbox"/> Animals	_____	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Rash <input type="checkbox"/> Other: _____
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Rash <input type="checkbox"/> Other: _____

Has your child been prescribed an EpiPen: Yes No

A note is required from the doctor for any allergy restrictions at school.

Please list any medication your child is currently taking.

Name of Medication:	Reason for Taking:	Home	School	Emergency
1. _____	1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If your child has a serious illness/allergy that requires medication, it is important to keep the medication at school.
 A medication authorization form must be completed by the parent/guardian and doctor to be kept on file at school.

I consent that information on this form may be shared with appropriate school personnel for health and educational purposes. The school nurse may consult with your child's physician regarding medical conditions and/or medications when necessary.

Parent/Guardian Signature: _____ Date: _____

**Carmi-White County Unit #5
Prekindergarten Consent to Enroll**

I give permission for my child, _____,
to be enrolled in the Carmi-White County Prekindergarten program.

Signature

Date

Witness

Teacher _____
Start Date _____ AM ___ PM ___
Check if Update _____

Carmi-White County Child Pick-Up and Health Information
School Year 2018-2019

Child's Name _____ Date of Birth _____

Parent's Name(s) _____

Home Address _____
(street and/or 911 address required)

Phone Home _____ Work _____ Cell _____

List all those who may pick up your child from school:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Directions to your home if on a rural route:

List any health information needed for emergencies (allergies, illnesses, etc):

LIBRARY CONTRACT

If your family would like to check out children's books from our classroom library please indicate so below.

Families will be responsible for the books they check out. If a book is lost or damaged, it will need to be replaced. Your teacher will be able to inform you of the cost in those situations.

Circle the appropriate response and return



YES! Our family would like to participate.

NO. Our family would not like to participate.

Child's Name _____

Parent/Guardian Signature _____