

Today's Date : ____/____/____

HCUSD #3 STUDENT ENROLLMENT FORM

Student's: Last Name	First Name	Middle Name	Preferred or Nick Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Sex: Birthdate: Birth Certificate: (County/State)

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Has this child attended a Hillsboro School before?

YES ____ NO ____

Grade _____
Teacher _____
School Bus # _____

Please indicate who the student is living with:

- 1-father & mother
 2-father
 3-mother
 4-guardian
 5-other _____

Parent/Guardian Information:

Name _____

Street: _____ P.O. Box _____

City & Zip _____, IL _____

Home Phone: _____ ☐Cell Phone: _____ ☐

Email address: _____

Does this student have an Individualized Education Plan?

YES ____ NO ____

ACTIVE DUTY MILITARY (REQUIRED)

YES ____ NO ____

Mother's Name	Mother's Occupation & Place of Employment	Mother's Work Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Father's Name	Father's Occupation & Place of Employment	Father's Work Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

*Please check the box next to any above phone number you DO NOT wish to have called as part of the Instant Messaging phone system.***Emergency Information:** In order to safeguard your child in case of early dismissal, illness, or accident: If you do not have a phone or cannot be reached, whom shall we contact and where shall we send your child?

Relative/Friend #1 :	Name:	Relationship:	Phone:
Relative/Friend #2 :	Name:	Relationship:	Phone:

Doctor's Info :	Doctor:	Doctor's Phone:
Hospital's Info:	Hospital's Name:	Hospital's Phone:

Child covered by: (Mark one) _____ Insurance _____ Medical Card _____ All Kids _____ Not covered

Health History	Yes	No
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>

Allergies (food or medicine): _____

Please state all medications being taken:

- 1.
- 2.
- 3.

Ethnic Code: (Check one)

Asian _____ Hispanic _____
 Black _____ White _____
 American Indian _____ Multi-Racial _____
 Other: _____

Is a language other than English spoken in the student's home? Yes ____ No ____
 If yes, which language? _____

Does the student speak a language other than English? Yes ____ No ____
 If yes, which language? _____

ADDITIONAL COMMENTS:

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Consent of Parent/Guardian: I agree to the release of health information on my child to appropriate school or health authorities and to Medicaid as needed for reimbursement.

Signature: _____
 Beckemeyer Elementary
 532-6994

Coffeen Early Childhood Center
 532-7822

X _____
 Hillsboro Junior High
 532-3742

X _____
 Hillsboro High School
 532-2841