Lick Creek CCSD #16

2023-2024 Student Information

Name: _____ **Date of Birth**: _____
First *Middle* *Last*

Primary Phone #: _____

Grade: _____ ☐Male ☐Female

Street Address: _____

City: _____, IL **Zip**: _____

☐Black/African American
☐Hispanic
☐Multiracial/Ethnic
☐White
☐Other (please specify)

Student Lives with *(check all that apply)*:
☐Mom
☐Dad
☐Step Parent
☐Grandparent(s)
☐Other Legal Guardian(s)

Bus Information *(check all that apply)*:
☐Will ride morning bus
☐Will ride afternoon bus
☐Parents will provide alternate transportation

To be filled in by office:
Miles from school:
Assigned to route

Parent Information

(Indicate which parent should be called first on routine matters)

Mother/Stepmother/Female Guardian **Contact this parent first?** _____

Name: _____ **Preferred Phone #**: _____
First *Last*

Mailing Address (If different from student address): _____

City: _____ **State**: _____ **Zip**: _____ **Email**: _____

Employer: _____ **Work Phone #**: _____ **Ext**: _____

Deployed or expect to be deployed to active duty in the US Armed Forces? _____ (Optional)

Father/Stepfather/Male Guardian **Contact this parent first?** _____

Name: _____ **Preferred Phone #**: _____
First *Last*

Mailing Address (If different from student address): _____

City: _____ **State**: _____ **Zip**: _____ **Email**: _____

Employer: _____ **Work Phone #**: _____ **Ext**: _____

Deployed or expect to be deployed to active duty in the US Armed Forces? _____ (Optional)

Continue on other side

Emergency Info

Please indicate if you would like the person listed on our TeacherEase notification system.

Additional Emergency Contacts (List in order of calling preference)

Name: _____ **Phone #**: _____ **Relationship**: _____
Would you like this person on the notification listing: Yes or No

Name: _____ **Phone #**: _____ **Relationship**: _____
Would you like this person on the notification listing: Yes or No

Name: _____ **Phone #**: _____ **Relationship**: _____
Would you like this person on the notification listing: Yes or No

General Medical Information

Allergies: _____

Medications: _____

Medical Conditions: _____

Physician Name: _____ **Physician Phone #**: _____

Department of Public Aid Recipient ID Number (If applicable): _____

Medicaid Case ID Number (If applicable): _____

Student Pick-up

Person(s) Authorized to Pick Up Child (Other than parents or emergency contacts listed above.)

Name: _____ **Phone #**: _____ **Relationship**: _____

Name: _____ **Phone #**: _____ **Relationship**: _____

Name: _____ **Phone #**: _____ **Relationship**: _____

Name: _____ **Phone #**: _____ **Relationship**: _____

After School Daycare

*Cost is $8 per child for the first hour (or fraction thereof) and $3 per child for each additional hour (or fraction) up to **5:30 pm**. After **5:30 pm** the cost increases to $10 per child per ¼ hour (¼ hour minimum). **Payment is required each Friday otherwise parent will need to make other arrangements for child's care until the balance has been paid in full.** Students who have not been picked up by 3:30 pm (2:30 pm on early dismissal days) & are not being directly supervised by a teacher or sponsor will be sent to After School Day Care.*

I agree to comply with the regulations of the Day Care Program.

Signature of Parent/Guardian: _____ **Date**: _____

Continue on other side