

Lick Creek CCSD #16
2024-2025 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)

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 $\frac{1}{4}$ hour ($\frac{1}{4}$ hour minimum). **Payment is required each Friday otherwise parents 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. Lick Creek engages and complies with the background check and clearance procedure through Illinois Department of Human Services CCAP currently available for license exempt CCAP providers. Our program/facility is not licensed or regulated by DCFS.

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

Signature of Parent/Guardian: _____ Date: _____