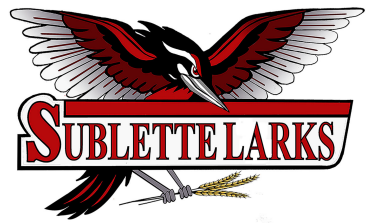


Student Information Form



STUDENT			
Grade	<input type="checkbox"/> Female <input type="checkbox"/> Male	Birth Date	
Last Name	First Name	Middle Name	
Elementary Only Proof of Age Provided (<i>CHECK ONE</i>) <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Hospital Record <input type="checkbox"/> Transcript <input type="checkbox"/> Other:			
Is the student Hispanic/Latino? <input type="checkbox"/> YES <input type="checkbox"/> NO		Do any of the following apply to the student? <input type="checkbox"/> 504 Plan—Disability accommodations not covered by Special Ed <input type="checkbox"/> Special Ed Services <input type="checkbox"/> ESOL / ELL Services	
What is the student's race? (<i>Please select one or more</i>)			
<input type="checkbox"/> American Indian OR Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black OR African American <input type="checkbox"/> Native Hawaiian OR Other Pacific Islander <input type="checkbox"/> White			
Student Physical Address		Student Mailing Address (<i>IF DIFFERENT FROM PHYSICAL ADDRESS</i>)	
	APT #		APT #
CITY, STATE	ZIP CODE	CITY, STATE	ZIP CODE
Student Cellphone Number			

PARENT / GUARDIAN #1			
LIVES WITH STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST NAME	FIRST NAME	MIDDLE NAME
RELATIONSHIP TO STUDENT	Mailing Address (if different from Student)	CITY, STATE	ZIP CODE
CHECK ALL THAT APPLY:			
CONTACT ALLOWED? <input type="checkbox"/> YES <input type="checkbox"/> NO HAS CUSTODY ? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO to Custody, Are MAILINGS ALLOWED? <input type="checkbox"/> YES <input type="checkbox"/> NO RELEASE TO ? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PRIMARY LANGUAGE	SPEAKS ENGLISH? <input type="checkbox"/> YES <input type="checkbox"/> NO	PARENT/GUARDIAN EMAIL	PLACE OF EMPLOYMENT
PRIMARY PHONE Number : <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TO CONTACT <input type="checkbox"/> UNLISTED		ALTERNATE PHONE Number : <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TO CONTACT <input type="checkbox"/> UNLISTED	

PARENT / GUARDIAN #2			
LIVES WITH STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST NAME	FIRST NAME	MIDDLE NAME
RELATIONSHIP TO STUDENT	Mailing Address (if different from Student)	CITY, STATE	ZIP CODE
CHECK ALL THAT APPLY:			
CONTACT ALLOWED? <input type="checkbox"/> YES <input type="checkbox"/> NO HAS CUSTODY ? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO to Custody, Are MAILINGS ALLOWED? <input type="checkbox"/> YES <input type="checkbox"/> NO RELEASE TO ? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PRIMARY LANGUAGE	SPEAKS ENGLISH? <input type="checkbox"/> YES <input type="checkbox"/> NO	PARENT/GUARDIAN EMAIL	PLACE OF EMPLOYMENT
PRIMARY PHONE Number: <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TO CONTACT <input type="checkbox"/> UNLISTED		ALTERNATE PHONE Number: <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TO CONTACT <input type="checkbox"/> UNLISTED	

STUDENT NAME**EMERGENCY CONTACTS**

1	RELATIONSHIP	NAME
PRIMARY PHONE :		ALTERNATE PHONE :
<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TO CONTACT		<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TOCONTACT
2	RELATIONSHIP	NAME
PRIMARY PHONE :		ALTERNATE PHONE :
<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TO CONTACT		<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TOCONTACT
3	RELATIONSHIP	NAME
PRIMARY PHONE :		ALTERNATE PHONE :
<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TO CONTACT		<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OK TOCONTACT

MEDICAL INFORMATION — THE SCHOOL CANNOT BE FINANCIALLY RESPONSIBLE FOR MEDICAL, DENTAL, AMBULANCE, OR HOSPITAL SERVICE.

PHYSICIAN'S NAME & Number	PREFERRED HOSPITAL	MEDICAID # (IF APPLICABLE)
Insurance Name / Group # / ID #		
ALLERGIES / HEALTH FACTORS / COMMENTS		
		LIFE THREATENING? <input type="checkbox"/> YES <input type="checkbox"/> NO

Please read and select Yes or No for each of the following.

- YES NO** In the event of serious injury, it may be necessary to contact local emergency medical personnel immediately. Attempts will then be made to contact the parents/guardians or designated persons to inform them of the situation. The child will be treated by medical personnel as needed.
- YES NO** In case of an illness or injury to the above named student, the school is authorized to proceed in its emergency medical plan including any necessary transportation to receive such treatment. I understand that the school is not financially responsible for individual medical, dental, ambulance, or hospital services. I realize that it will be necessary for me to inform the school of any address or phone number changes that may occur during the school year. I understand that the coaches/sponsors of my child will be prepared to take the appropriate emergency steps by keeping a copy of this form with them at all contests and activities.
- YES NO** I give permission for the exchange of information between the school nurse or other school representative to copy and send this student's immunization records to schools, physician's offices, and health departments as needed.
- YES NO** I give permission to USD #374 or its designated representative to permit my child's picture to be taken or likeness reproduced and disseminated to various media/communications, such as local newspapers and the district's website. I hereby release the above party from liabilities arising out of what I might deem misrepresentations by virtue of distortion, optical illusions or faulty mechanical reproductions. The publicity of that minor child received by virtue of the first such use that may be made thereof shall be full and adequate compensation for this consent. I agree all such uses of his/her name, voice, likeness, portraits, pictures, photographs, films videotapes, audiotapes, or writings and reproductions thereof, including but limited to tapes, plates, and negatives connected therewith are and shall remain property of USD #374.

Middle/High School ONLY

YES NO My child has permission to leave campus for school sponsored events during the school year.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

Student Health Information Form

Last Name

First Name

Grade

Date of Birth

Emergency Contact Numbers

Please check any medical conditions your student has:

- | | | |
|---|--|--|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Serious Injury |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Bone/Joint problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Vision Difficulties | <input type="checkbox"/> Surgical History |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Heart Defects | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Urinating Problems | <input type="checkbox"/> Constipation |
| | | <input type="checkbox"/> Other |

Please explain checked medical conditions or anything more about your student's health that you think is important for us to know:

Allergies (Drug & Food) & Reaction:

1.

2.

3.

Home Medications / Vitamins:

1.

2.

3.

Assistive Devices: (glasses, contacts, braces, hearing aids etc)

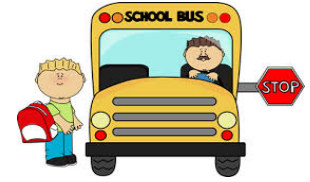
1.

2.

3.



Sublette School District Transportation 2024-2025



PLEASE PRINT CLEARLY

Family's Last Name: _____

1st Child's Name	Grade
3rd Child's Name	Grade
5th Child's Name	Grade

2nd Child's Name	Grade
4th Child's Name	Grade
6th Child's Name	Grade

Do you live in town or in the country? Town: Country:

Will your child(ren) ride the bus? Yes: No:

If you live in the country what is your physical address:

Directions to your home from Sublette:

Phone Numbers

	Home Phone	Cell Phone	Work Phone
Mother's Name:			
Father's Name:			
Nearest Neighbors:	Home Phone	Cell Phone	Work Phone

If no one is at home when we arrive to drop off your child(ren) after school, what do you want the driver to do?

- Drop your child(ren) off anyway.
- Take my child(ren) back to the school.

Mud Routes

Some parents elect to have their child(ren) walk home from their mud route stop. Do you want us to allow your child to:

- Walk home from the mud stop.
- Take my child(ren) back to the school.

Parent Signature

Date