



(Complete Reverse Side)

**Emergency Contacts**

**Emergency Contacts: (Someone who is able to pick up your child in your absence - must be 18 years old - Please list at least two)**

Full Legal Name                      Phone #/Phone Type                      Relationship to Student

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Automated Phone System**

In the event of a school closing, an emergency, or other district information, we need to obtain the following:

**Parent/Guardian Phone Number (please list in order of availability to reach you)**

Phone 1: \_\_\_\_\_  
Phone 2: \_\_\_\_\_  
Phone 3: \_\_\_\_\_

The Three Lakes School District uses an automated phone system to communicate with parents. Emergency messages will be sent to all of these numbers. Contact preferences can be changed at any time by accessing the parent portal.

**Medical/Health Information**

The following information about your child will help us in the event of an emergency.

Will your child need to take medication during school hours: Yes No

**\*If yes, a completed Prescription or Non-Prescription authorization form is required**

**Medical Conditions (Check any/all that apply)**

Diabetes Asthma Epilepsy Heart Disease ADD/ADHD Vision/Hearing Other \_\_\_\_\_

**Medication**

(indicate whether home or school use, including inhalers)

**Allergies**

(\*food, insect, medication, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* A child with a food allergy must be provided substitutions in foods, when that need is supported by a statement signed by a licensed physician

Doctor: \_\_\_\_\_ Clinic Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

➔ **If there is an emergency and we are not able to contact you, may the school authorities use their own judgment in calling for medical assistance?** Yes No

\*\* All immunization records must be provided within 30 days of enrollment

**Previous School Information (if applicable)**

Last school (or district) this student attended: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of Counselor and/or Principal: \_\_\_\_\_

Has this student ever been expelled? Yes No

Is this student under an expulsion order at this time? Yes No

Does this student currently receive Special Education or 504 Services? Yes No

I agree that the information provided herein is complete and accurate. I understand that this information is being used by the school district for the purposes of registering my child. I agree to promptly inform the school district of any changes in this information, including any changes in the residency of my child.

Parent/Guardian Name (Print) \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

**Office Use Only**

Primary Teacher \_\_\_\_\_ Art Teacher  Band Teacher  Music Teacher  PE Teacher  IT  Principal

Transportation Office  Guidance  Kitchen  Sp. Ed.  Library