

Office Use Only  
 Registration Date: \_\_\_\_\_  
 Records Requested Date: \_\_\_\_\_  
 Birth Certificate Verification Date: \_\_\_\_\_  
 Residency Verification Date: \_\_\_\_\_

**STUDENT INFORMATION CARD  
 MEQUON-THIENSVILLE SCHOOL DISTRICT**

**STUDENT INFORMATION**

|   |                 |                           |   |                      |                 |
|---|-----------------|---------------------------|---|----------------------|-----------------|
| Student Last Name:  |                 | Student First Name:       |   | Student Middle Name: | Grade Entering: |
| Student Street Address:   |                 | Student City, State, Zip: |   | Gender:<br>M F       | Date of Birth:  |
| City of Birth:  | State of Birth: | Country of Birth:         |   | County of Birth:     |                 |
| With Whom Does Student Reside? <b>(circle each that applies)</b><br>Both Parents/Same House    Father    Mother<br>Guardian    Step-Father    Step-Mother |                 |                           | How long have you and your child resided in Mequon-Thiensville? |                      |                 |

**PARENT / GUARDIAN INFORMATION**

| Primary Guardian     | Second Guardian <i>(This section for Joint Custody)</i> |
|----------------------|---|
| Guardian 1 Name(G1): | Guardian 3 Name (G3):                                   |
| Home Address:        | Home Address:   |
| City/State/Zip:      | City/State/Zip:   |
| Home Phone:          | G3 Home Phone:  |
| G1 Employer:         | G3 Employer:  |
| G1 Work Phone:       | G3 Work Phone:  |
| G1 Cell Phone:       | G3 Cell Phone:  |
| Home E-Mail address: | G3 Home E-Mail address:                                 |
| Guardian 2 Name:     | Guardian 4 Name:  |
| Employer (G-2):      | Employer (G-4):   |
| Work Phone (G-2):    | Work Phone (G-4):                                       |
| Cell Phone (G-2):    | Cell Phone (G-4):                                       |

**EMERGENCY INFORMATION** Name(s) of person(s) to be called when parent/guardian cannot be reached.

| Name | Relationship | Daytime Phone/Cell Phone |
|------|--------------|--------------------------|
|      |              |                          |
|      |              |                          |

**MEDICAL INFORMATION**

|  |                |
|--|----------------|
| Doctor Name:   | Doctor Phone:  |
| Dentist Name:  | Dentist Phone: |
| Circle if appropriate:            Diabetes            Allergy            Asthma            Heart            Seizures   |                |
| List any Medication and/or Allergies:  |                |
| Will your child require the taking of prescription/non-prescription medication at school?            YES            NO |                |
| Explain any other health conditions:   |                |
| Physical restrictions:   |                |

If, in the judgment of school authorities, emergency treatment is required, I authorize my child to be transported by ambulance to a hospital for treatment. I understand that the contacted ambulance provider does reserve the right to convey the patient to the nearest definitive care hospital or the hospital of their choice, should they deem it necessary. I hereby authorize the physician(s) at the hospital to give emergency treatment to my child. To the best of my knowledge, the above information is current and correct.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**SIBLING INFORMATION**

| First Name | Last Name | Gender | Date of Birth | Grade | School |
|------------|-----------|--------|---------------|-------|--------|
|            |           |        |               |       |        |
|            |           |        |               |       |        |
|            |           |        |               |       |        |
|            |           |        |               |       |        |

**LAST SCHOOL ATTENDED** (For entering kindergarten students, please list any preschool attended.)

|                                       |   |                       |               |
|---------------------------------------|---|-----------------------|---------------|
| School Name:                          |   | Last grade completed: |               |
| Address:                              | City/State:   | Zip:                  | Phone:<br>( ) |
| Year student began schooling in U.S.: | Has your child been expelled from a previous school district? |                       | Yes No        |

**Is your child presently participating in any of the following programming options?**

|  |     |    |
|--|-----|----|
| 504 Accommodation Plan   | Yes | No |
| Did the student first learn to speak a language other than English and/or reside in a household where a language other than English is spoken? If yes, which language: | Yes | No |

**The following information is to be used as part of the screening process required under PI 11.02(2)(b) to identify students who require, or possibly require, special education services. Does your student have any of the following conditions?**

|                                      |     |    |   |     |    |
|--------------------------------------|-----|----|---|-----|----|
| Specific Learning Disability (SLD)   | Yes | No | Autism (A)  | Yes | No |
| Emotional Behavior Disturbance (EBD) | Yes | No | Cognitive Disability / Other Developmental Disability (CC/DD) | Yes | No |
| Speech and Language Handicap (SL)    | Yes | No | Orthopedic Impairment (OI)                                    | Yes | No |
| Traumatic Brain Injury (TBI)         | Yes | No | Other Health Impairment (OHI)                                 | Yes | No |
| Visual Impairment (VI)               | Yes | No | Significant Developmental Delay (SDD)                         | Yes | No |
| Hearing Impairment (HI)              | Yes | No | Other, List:  |     |    |

|  |           |        |
|--|-----------|--------|
| Has your student ever been evaluated or placed in a program for special education needs? (This includes early childhood services before starting kindergarten.) If yes, please describe: | Yes       | No     |
| Do you have any younger children (ages 0-5) that may be eligible for special or exceptional programs? If yes, please list them below.  | Yes       | No     |
| First Name   | Last Name | D.O.B. |
|  |           |        |
|  |           |        |

|  |
|--|
| Is there any other information that would be helpful for the school to know: |
|  |

|  |   |  |
|--|---|--|
| Ethnicity  | <b>PLEASE COMPLETE BOTH SECTIONS BELOW:</b> |  |
| 1. CHOOSE ONE:   | <b>AND</b>                                  | 2. CHOOSE ONE OR MORE:   |
| <input type="checkbox"/> Hispanic or Latino<br><input type="checkbox"/> Not Hispanic or Latino |   | <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American<br><input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White |

**As a parent/guardian, I hereby affirm we presently reside in the Mequon-Thiensville School District. The information provided on this form is correct to the best of my knowledge.**

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_