Current Date _____ **DIXON PUBLIC SCHOOLS REGISTRATION INFORMATION**

For Office Staff Only
☒ New Family ☐ Proof of Residency

School _____ Starting Date _____

Student's Legal Last Name _____ Student's Legal First Name _____ Middle _____

Birth Date _____ Grade _____ Gender _____

Home Address _____ City _____ Zip Code _____

Home Phone _____ Unlisted? ☐ Cell Phone _____

Ethnicity: ☐ Hispanic OR If Non-Hispanic please choose one of the following: ☐ White ☐ Black or African American ☐ 2 or more races ☐ Asian ☐ American Indian or Alaskan Native ☐ Other Pacific Islander

Are you living with friends or relatives because of your financial situation or are you homeless? ☐ Yes ☐ No

Has this student ever attended Dixon Public Schools? ☐ No If yes, what school _____

IF TRANSFERRING, Name of Previous School _____

Address/City/State _____

HOME LANGUAGE SURVEY:

Is a language other than English spoken in your home? ☐ No ☐ If yes, what language _____

Is this the primary language in the home? ☐ No ☐ Yes

Does your child speak a language other than English? ☐ If yes, what language? _____

**If you answered yes to the above language questions, the law requires to test your child's English Language proficiency. The school will measure your child's listening, speaking, reading, & writing skills.*

Is this child a Foster Child? ☐ Yes Placed by _____ (please supply our office with documentation)

If yes, does the biological parent live in the Dixon School District? ☐ Yes ☐ No

SPECIAL SERVICES:

Is this student receiving Special Education Services or have a current IEP? ☐ Yes ☐ No

Type of Service

Does the child have any known: ☐ Speech/Language Needs ☐ Hearing Problems ☐ Vision Problems ☐ Advanced Skills ☐ Disabilities

Does this student have at least one Parent or Guardian who is an active member of the Army, Navy, Air Force, Marine Corps, or Coast Guard that is full-time in the military service of the United States? ☐ Yes ☐ No

GUARDIAN INFORMATION:

Mother's Last Name _____ First Name _____ ☐ Lives with Student

If you do not live with the student, what is your address? _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Email address _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Do you have sole custody: ☐ Yes (If yes, please supply our office with documentation) ☐ No ☐ Joint Custody?

Father's Last Name _____ First Name _____ ☐ Lives with Student

If you don't live with the student, what is your address? _____

Home Phone _____ Cell Phone _____

Employer: _____ Work Phone _____

Email address _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Do you have sole custody: ☐ Yes (If yes, please supply our office with documentation) ☐ No ☐ Joint Custody?

Step Mother's Last Name _____ First Name _____ ☐ Lives with Student

Address _____ Employer _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Step Father's Last Name _____ First Name _____ ☐ Lives with Student

Address _____ Employer _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Other Legal Guardian's Last Name _____ First Name _____ Lives with Student ☐

Address _____ Employer _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Emergency Information: **Please list in order, who should be called if we need to contact you about your child during the day for illness, etc…** ***(List yourself in the order you want to be notified, if you so desire)***

1. Name _____ Relationship _____ Home Phone _____
   Alternate Phone _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No
2. Name _____ Relationship _____ Home Phone _____
   Alternate Phone _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No
3. Name _____ Relationship _____ Home Phone _____
   Alternate Phone _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No
4. Name _____ Relationship _____ Home Phone _____
   Alternate Phone _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Physician _____ Office Phone _____

Daycare Provider _____ Phone _____

List Name (s) of other children in your household:

Name _____ Relationship _____ Year Born _____ ☐ Male ☐ Female

Name _____ Relationship _____ Year Born _____ ☐ Male ☐ Female

Name _____ Relationship _____ Year Born _____ ☐ Male ☐ Female

Name _____ Relationship _____ Year Born _____ ☐ Male ☐ Female

Please Sign: _____ **This form can only be signed by a parent or guardian**

DIXON PUBLIC SCHOOLS #170

"A Place to Grow"

www.dps170.org

1335 Franklin Grove Road
Dixon, Illinois 61021

Phone: (815) 284-7722
Fax: (815) 284-8576

Margo Empen, Superintendent
Dan Rick, Asst. Superintendent

Parents/guardians:

The State of Illinois is required to identify the race and ethnicity of all students in order to comply with new federal standards. This information will be used in reporting aggregate data to the U.S. Department of Education.

Dixon Public Schools will need to re-identify the race and ethnicity of ALL students.

If you have any questions, or need help in completing this form, please contact us or your child's school.

Thank you for your help in collecting this information.

Child's Name _____ Grade _____

School _____

Please choose one ethnicity - _____ Hispanic/Latino
_____ Non-Hispanic

If you selected Non-Hispanic, please choose one of the following races* below:
***(for a better description of the races – please see the back page) →**

_____ White _____ Black or African American _____ Asian

_____ Native Hawaiian or Other Pacific Islander

_____ American Indian or Alaskan Native

_____ Two or more races

Parent/guardian signature _____

Dixon Public Schools, in cooperation with the community, will provide students with a comprehensive educational program that produces well-educated, self-sufficient, and involved citizens.

Descriptions of Ethnics & Races –

Hispanic/Latino
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

White
A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Black or African American
A person having origins in any of the black racial groups of Africa.

Asian
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Native Hawaiian or Other Pacific Island
A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

American Indian or Alaska Native
A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliation or community attachment.

Two or more races (formerly Multi-racial)
A person having origins in more than one race.

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Registration/Residency Guidelines

If you are registering your child with Dixon Public Schools for the first time, you will be asked to provide proof of residency. Examples of proof of residency include any of the following: utility bill, lease agreement, property tax statement, mortgage statement, vehicle title or registration card, pay check/pay stub, insurance policy, their person affidavit of residency (from landlord or dwelling owner), checking or savings account statement, etc.

Please determine which of one of the five situations most clearly reflects the reason the student lives within the boundaries of the Dixon Public Schools.

1. _____ The student lives with his or her natural or adoptive parents, the student is a resident of the school district in which his or her natural or adoptive parents live.

2. _____ If a court has granted custody, not guardianship, to an adult with whom the student lives, then the student is a resident of the district in which that adult lives, as long as the student is not living with the adult for access to the educational programs of the district.

3. _____ If an adult has been granted short-term guardianship by the court system, then the student is a resident of the district in which that adult lives, as long as the student is not living with the adult for access to the educational programs of the district. (*Please verify short-term guardianship)

4. _____ If a student lives with an adult relative caretaker receiving aid under the Illinois Public Aid Code for that student, then the student is a resident of the district in which that adult lives, as long as the student is not living with the adult for access to the educational programs of the district.

5. _____ If the student lives with an adult who has accepted responsibility for the student and provides a fixed nighttime abode for the student, then the student is a resident of the district in which that adult lives, as long as the student is not living with the adult for access to the educational programs of the district. (*Must complete Affidavit of Enrollment and Residency Form on the other side of this form.)

Student's Name: _____
(please print clearly)

_____	_____	_____
Date	Adult Name (print name clearly)	Adult Name (Signature)

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ILLINOIS STATE BOARD OF EDUCATION

AFFIDAVIT OF ENROLLMENT AND RESIDENCY

This affidavit form may be used if you are an adult who has assumed responsibility for a pupil and provide the pupil with a fixed, night-time abode, for reasons other than access to the educational programs of the school district.

This form should *not* be used, however, if you are the natural or adoptive parent of the pupil, have been granted court-ordered custody or guardianship, or are receiving public aid on behalf of the pupil. For these situations, you are only required to provide documentation (such as a birth certificate or court order), without the need of an affidavit like this one.

This form is also *not* required for pupils who are sharing the housing of others due to lack of housing, economic hardship, or similar reason, or are otherwise homeless as defined in state and federal law. Homeless pupils must be enrolled immediately.

If you have *any* questions about residency, including homelessness, please contact the Illinois State Board of Education's Educator and School Development Division at (217) 782-2948.

I, _____ (*Name of Adult*), reside at _____ (*Address*), which is located within the boundaries of _____ (*School District*).

Provide the appropriate information and check each of the following:

☐ I am at least 18 years of age.

☐ I have provided proof in the form(s) of _____ (*Proof of Residency*)

that I am a resident of _____ (*School District*).

☐ I have assumed and exercise responsibility for _____ (*Name of Pupil*).

☐ I provide a fixed, night-time abode for _____ (*Name of Pupil*).

☐ _____ (*Name of Pupil*) is not living with me for the purpose of having access to the educational programs of the school district.

☐ I understand that knowingly or willfully providing false information to a school district regarding the residency of a pupil for the purpose of enabling that pupil to attend any school in that district without the payment of nonresident tuition is a Class C misdemeanor.

☐ I understand that knowingly enrolling or attempting to enroll a pupil in the school of a school district of a tuition free basis when I know that pupil to be nonresident of the school district, unless the nonresident pupil has a lawful right to attend, is a Class C misdemeanor.

_____	_____	_____
Date	*Signature of Adult*	*Adult (Print Name)*
_____	_____	_____
Date	*School District Employee (Signature)*	*School District Employee (Print Name)*

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DIXON PUBLIC SCHOOLS
AUTHORIZATION SHEET

Rev. July, 2012

STUDENT'S NAME_____ **GRADE**_____
(Please Print)

FIELD TRIPS:

Please allow the above student to participate in scheduled field trips. _____ **Please initial**

HANDBOOK:

I acknowledge that the Student/Parent Handbook is available to view on the DPS Website.

_____ **Please initial**

Notice to Parents Student Pictures/Images/Publications

I give permission for the above student to have their photo printed in a school yearbook and class photo.
Yes ☐ **No** ☐ **Check One**

I grant consent to the Dixon School District to identify a picture of the above student, by full name and/or the school he or she attends, in any school sponsored material, publication, videotape, or web site. This consent is valid for the entire time the above student is enrolled in Dixon Public Schools. I may revoke this consent at any time by notifying the building Principal.
Yes ☐ **No** ☐ **Check One** _____ **Please initial**

INTERNET/ACCELERATED READER: Both you and your child must sign this agreement:

Electronic Network Access Acceptable Use Policy Agreement

I understand and will abide by the Authorization for Electronic Network Access. I further understand that should I commit any violation, my access privileges will be revoked, and school disciplinary action and/or appropriate legal action may be taken. In consideration for using the District's electronic network connection and having access to public networks, I hereby release the District and its School Board members, employees, and agents from any claims and damages arising from my use, or inability to use the district's electronic network access. I acknowledge that I have read and understand the Student's Acceptable Use Policy on the District's Website.

Date _____ **Student Signature** _____

I have read this Authorization for Electronic Network Access. I understand that access is designed for educational purposes and that the District has taken precautions to eliminate controversial material. However, I also recognize it is impossible for the District to restrict access to all controversial and inappropriate materials. I will hold harmless the District, its employees, agents, or Board of Education members, for any harm caused by materials or software obtained via the electronic network. I accept full responsibility for supervision if and when my child's use is not in the school setting. I have discussed the terms of this Authorization with my child. I hereby request that my child be allowed access to the District's electronic network connection. . *The entire Acceptable Use Policy can be viewed on our website under the "Parents" link, Registration Forms. I acknowledge that I have read and understand the Student's Acceptable Use Policy on the District's Website.

Parent/Guardian Signature_____

PARENT MEDICATION CONSENT FORM

Student Name: _____ Birthdate: _____ Grade: _____

I consent for my child to take Tylenol at school

_____ Yes or No - Please select one

I consent for my child to take Ibuprofen at school

_____ Yes or No - Please select one

Concerns you would like us to be aware of (allergies, asthma, health restrictions, etc.) - PLEASE check mark all that apply:

☐ Asthma (Please provide nurse with Asthma Action Plan from doctor). ☐ Diabetes ☐ Seizures

☐ Allergies-Please list - _____

Other concerns: _____

If your child has any of these conditions - Asthma, Seizures, Food Allergies, or Diabetes, an action plan form will need to be completed by a physician and given to the school nurse. You can access these forms on our website - http://www.dps170.org/departments/health-services.

I would like my child's Emergent (inhaler, epi-pen) medication to be:

☐ Stored in the Nurse's Office ☐ Carried on Self

Name of medication: _____

By Signing Below, I Agree:

1. I hereby authorize District Public Schools and its employees on my behalf to allow my child to self administer medication while under the direct supervision of an employee of District Public Schools. I acknowledge that it may be necessary for the supervision of administration to my child be performed by an individual other than a school nurse, and specifically consent to such practice.
2. To indemnify and hold harmless District Public Schools and its employees against any claims, except a claim based on willful and wanton conduct, arising out of the self administration of medication by the child.
3. Agree that the above information may be shared with appropriate personnel for health and educational purposes.
4. I consent to any x-ray, examination, anesthetic, medical and or surgical diagnosis, medical treatment or hospital care, to be rendered to the minor child under the general or special supervision and on the advise of any physician or surgeon licensed to practice in the State when need for such treatment is immediate. This will be used only when reasonable effort to contact me or the emergency contact person(s) is unsuccessful.

_____ _____

Guardian/Parent Signature Date

* Complete only if there are concerns *

Academic

Parental Concerns

Emotional

Behavioral

Student's Name: _____ Parent/Guardian Name: _____

Grade Level: _____

Concerns:

_____

_____

_____

_____

Please share the above information with the following people:

- ☐ Counselor
- ☐ Principal
- ☐ Teacher
- ☐ Nurse
- ☐ All of the above

Please mark the appropriate response:

Has your child received counseling services? Yes / No Where did counseling occur? _____

Please sign to show you have read the information on this form.

Parent Signature: _____

(Rev. 06/2015)

Dixon Public Schools #170

Physician's Medication Authorization

(To be used if student takes a prescribed medicine at school.)

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

School: _____ Grade: _____ Teacher: _____

Physicians' Direction: Dixon Public Schools (Policy #270.14) states "That self-administration of prescription medicines by pupils will be done only in the exceptional circumstances wherein the child's health, behavior/attention span may be in jeopardy without it. If medication must be self-administered, it must be under the following conditions:

1. A signed order by a physician with specific directions for administration must be submitted to the school nurse (District Health Services Coordinator).
2. If the medication is a prescription medication, a container with a pharmacist's label designating patient's name and name of physician must be submitted to the schools"

Physician's Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Prescription Medication: _____

_____

Dosage: _____ Time: _____ Frequency: _____

Medication shall be administered under what circumstances: _____

_____

Diagnosis required medication: _____

Must this prescription medication be administered during the school day in order for the child to attend school or to address the student's medical condition? _____Yes _____ No

Side Effects: _____

Other medications student is receiving: _____

_____

_____ _____

Physician's Signature Date

MEDICATION ADMINISTRATION IN DIXON PUBLIC SCHOOLS

Guidelines for Prescription Medications:

Medications should be limited to those required during school hours and necessary to maintain the

1. child in school.
2. Medication must be brought to school by an adult in the original prescription container from the
3. pharmacy or physician's office properly labeled including current date. You should contact your pharmacy
4. for an extra bottle for school usage.
5. Each dose of medication shall be documented in the child's health record. Documentation shall
6. include: date, time, dosage, route and the signature of the person supervising the self-administration. In the event a dosage is not administered as ordered, the reason shall be entered into the record. Any side effects shall be assessed and documented as necessary in the child's health record.
7. All medication orders shall be renewed at the beginning of each school year by the child's physician. Changes in medication shall have written authorization from the licensed prescriber.

Guidelines for Over the Counter Medications (OTC):

1. OTC medication shall require parental permission for student to take any OTC medication at school. A physician's signature is optional.
2. OTC medications shall be brought in the manufacturer's original container with the administration guidelines listed and child's name affixed to the container. All OTC medication brought to school must have an unexpired date clearly printed on the container or box.
3. The parent/guardian will be responsible for being sure the parent and physician portion of the Medication Authorization Form are completed and signed and on file at the student's school.

Guidelines for Emergent Medications (inhalers, epi-pens):

1. According to a law passed in 2006, students will be allowed to carry their inhalers and epinephrine auto-injectors (epi-pens) on their person to be able to self-administer as needed in a medical crisis.
2. The parent/guardian will be responsible for being sure the parent and physician portion of the Medication Authorization Form are completed and signed and on file at the student's school.

MEDICATION ADMINISTRATION IN DIXON PUBLIC SCHOOLS

The purpose of administering medications in school is to help each child maintain an optimal state of health to enhance his or her education. Medication should be limited to those required during school hours and necessary to provide student access to the educational program.

The intent of these guidelines is to reduce the number of medications given in school, yet assure safe administration of medications for those children who require them.

The objective of any medication administration program is to promote self-responsibility.
This can be achieved by educating students and their families.

Guidelines for Prescription Medications:

1. All prescription medications given in school shall be prescribed by a licensed prescriber on an individual basis as determined by the child's health status and the Medication Authorization Form shall be completed by both the parent/guardian and the physician.
2. A written order for medication must be obtained from the child's licensed prescriber and include the following:
    * Child's Name
    * Child's Date of Birth
    * Licensed Prescriber Phone and Emergency Number(s)
    * Name of Medication
    * Dosage and Route of Medication
    * Frequency and Time of Administration
    * Date of Prescription
    * Discontinuation Date
    * Diagnosis Requiring Medication
    * Intended Effect of Medication
    * Possible Side Effects
    * Other Medication Child is Currently Taking

3. Medication will be stored in a separate locked drawer or cabinet in the Nursing Office. Medication requiring refrigeration will be refrigerated in a secure area. Students are not allowed to carry any prescription or non-prescription medication on their self at any time (except emergent medication; inhaler, epi-pen).

4. It is the parent/guardian's responsibility to ensure that the Physicians Medication Authorization Form and the Parent Medication Form are completed and signed by both the physician and parent, and returned to the student's school.

5. The parent/guardian will be responsible at the end of the treatment regime for removing from the school any unused medication which was prescribed for their child. If the parent/guardian does not pick up the medication at the end of the school year, the Health Assistant at the student's school will discard the medication in the presence of a witness. The disposal will be documented in the child's health record. 6. All medication taken at school will be self-administered with supervision.

6. All medication taken at school will be self-administered with supervision.

STUDENT TRANSPORTATION FORM -2018-19

(STUDENTS CAN ONLY HAVE A MAXIMUM OF 2 ADDRESSES FOR BUSSING - A.M. AND P.M. ADDRESS.)

Student name: _____ School _____ Grade _____

(MORNING PICK UP WILL BE BASED ON THIS ADDRESS:)

AM Pick up Address: _____

☐ Please check mark the box if this is the sitter address. OR ☐ This is the home address.

(AFTERNOON DROP OFF WILL BE BASED ON THIS ADDRESS:)

PM Drop Off Address: _____

☐ Please check mark the box if this is the sitter address. OR ☐ This is the home address.

Student's home address if different than above: _____

Parent/Guardian Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

How will the student typically get to school?

☐ Bus# ☐ Walk ☐ Private Vehicle Other: _____

How will the student typically get home from school?

☐ Bus# ☐ Walk ☐ Private Vehicle

☐ Sitter - please complete info. below:

Sitter Name: _____ Sitter phone: _____

A 24 to 48 hour notice must be given to the Bus Company when changing route information.

Call 815-284-8600 for questions.

*****FOR ILLINOIS CENTRAL BUS CO. OFFICE USE ONLY - ROUTING INFORMATION*****

AM		PM	
Route	**Time**	**Route**	**Time**

Route #: _____

Route Shuttle: _____

Comments: