



MOUNT HOREB AREA SCHOOL DISTRICT
4K Student Enrollment Form

1304 E LINCOLN STREET
MOUNT HOREB, WI 53572
Please complete and return
this form as soon as possible.

Enrolling Student Information: Please answer all the questions.

Name: Last First Middle Birth Date:

Preferred Name to be Called (if different)

Current Address: Home Phone #: Unlisted: Yes No

Age: Gender: Enrollment Date: (Complete if not first day of school.)

Is this student Hispanic/Latino? Yes No

Race: Choose all that apply White Black/African American Native Hawaiian/Pacific Islander American Indian/Alaska Native Asian

Ethnicity: Please choose one White, not Hispanic Black, not Hispanic Hispanic/Latino Asian/Pacific Islander American Indian/Alaska Native

Received/Receiving Special Education Services? Yes No

1. Original Birth Certificate must be with you at the time of registration for verification. Birth City: County: Birth State: MHASD Staff Verification Initials: Date:

2. Proof of Residency must be with you at the time of registration for verification. Utility Bill -- Payroll Stub -- Lease Agreement -- Other: MHASD Staff Verification Initials: Date:

Enrolling Parent/Guardian Information: Please list each parent/guardian's information separately.

1 Name: Relationship to Student:

Current Address: Cell Phone #: ( )

(if different than above) Work Phone #: ( )

E-mail Address: Employer:

2 Name: Relationship to Student:

Current Address: Cell Phone #: ( )

(if different than above) Work Phone #: ( )

E-mail Address: Employer:

Does student live at this address full time? Yes No If no, please list other names and addresses:

3 Name: Relationship to Student:

Current Address: Cell Phone #: ( )

Work Phone #: ( )

E-mail Address: Employer:

**Emergency Contact Information:** The person to be notified in an emergency when parents / guardians cannot be reached. Other than those listed on front page.

1 Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell Phone #:(\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

This person is authorized to pick up the child.  Yes  No (Only authorized persons will be able to pick up child at 4K site.)

2 Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell Phone #:(\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_

This person is authorized to pick up the child.  Yes  No (Only authorized persons will be able to pick up child at 4K site.)

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**Legal Information:** This information will be entered into our student information system and shared with appropriate staff.

1. Is this student a foster child?  Yes  No If "Yes", name of caseworker? \_\_\_\_\_ Ph#: \_\_\_\_\_

2. a. Are there court restrictions associated with this child?  Yes  No

b. Are there court restrictions associated with who should be receiving educational mailings for this child?  Yes  No

**Court documentation must be provided in order for these restrictions/requests to be honored.**

Restrictions: \_\_\_\_\_

**Health and Medical Information:** This information will be shared with the appropriate staff to meet the educational and safety needs of your child. Please check and comment for the appropriate answers.

3. Does your child have a life threatening condition?  Yes  No If "Yes", please explain: \_\_\_\_\_

4. Does your child have any conditions that would have a direct effect on participation in school activities?  Yes  No

If "Yes", please explain: \_\_\_\_\_

Allergies: (To what?) \_\_\_\_\_

Asthma: \_\_\_\_\_

5. Is your child on any regular medications or an inhaler?  Yes  No If "Yes", for what? \_\_\_\_\_

6. Is your child's activity restricted in any way?  Yes  No If "Yes", please explain: \_\_\_\_\_

7. Does your child have an epi-pen?  Yes  No If "Yes", for what? \_\_\_\_\_

8. Name of Preferred Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

9. Name of Preferred Dentist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**If you have any concerns regarding the health of your child, please contact the school district nurse, 437-2400 x5104.**

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

Local ID Number: _____	For Office Use Only:	Copied to: Nurse
Proof of Residency: Yes		Date Enrolled: _____
		Birth Certificate: Yes