

LA CROSSE SCHOOL DISTRICT STUDENT ENROLLMENT FORM 2013-2014

Student Legal Name (Last, First, Middle): _____ School: _____

Primary Address: _____ Grade: _____ Grad Year: _____

City, State, ZIP: _____ Gender: _____ Birth Date: _____

Mailing Address (if different from above): _____ Language spoken at home: _____

_____ Birthplace-City/State/County: _____

Home Phone: _____ Unlisted: Y/N _____ Previous School: _____

Homeroom #: _____ Teacher: _____ Previous School City/State: _____

Student Accident Insurance - I have been offered an optional student accident insurance policy from Student Assurance Services, Inc. (Check one below)

I have purchased the optional student accident insurance policy from Student Assurance Services, Inc.

I have adequate insurance coverage for my son/daughter in case of an accident. I waive this coverage.

Ethnicity: Step 1: Select one below:

- Hispanic or Latino
- Not Hispanic or Latino

Race: Step 2: Please mark one or more choices below:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Primary Legal Guardian (with whom the child PRIMARILY lives)

Name: _____	Spouse's/Partner's Name: _____
Relationship: _____	Relationship: _____
Address: _____	Employer: _____
Home Phone: _____	Work Phone: _____
Work Phone: _____	Cell Phone: _____
Cell Phone: _____	E-mail: _____
E-mail: _____	
Employer: _____	

COURT ORDER: Y/N

NOTE: Court Order MUST be on file in School office in order to implement the Court Order!

OTHER LEGAL GUARDIAN

Name: _____	Spouse's/Partner's Name: _____
Relationship: _____	Relationship: _____
Address: _____	Employer: _____
Home Phone: _____	Work Phone: _____
Work Phone: _____	Cell Phone: _____
Cell Phone: _____	E-Mail: _____
E-mail: _____	
Employer: _____	

LOCAL EMERGENCY CONTACT INFORMATION

Please list the names of contacts the schools should use in case of an illness / emergency IF LEGAL PARENTS ARE NOT AVAILABLE

Name	Relationship	Phone 1-Primary	Phone 2-Work	Phone 3-Cell

Doctor: _____ Phone: _____ Hospital: _____ Phone: _____

Dentist: _____ Phone: _____

NOTE: PLEASE COMPLETE THE DIRECTORY DATA FORM AND SIBLING INFORMATION ON REVERSE SIDE!