

# Lincoln-Way Area Special Education Joint Agreement District #843

601 WILLOW STREET • FRANKFORT, IL 60423 • PHONE: (815)806-4600 • FAX: (815)806-4601

## STUDENT PERSONAL DATA FORM FOR SCHOOL YEAR \_\_\_\_\_ TO BE COMPLETED BY PARENT/GUARDIAN – Must be completed even if your child is not being bused

Resident District \_\_\_\_\_ Date \_\_\_\_\_  
Student Name \_\_\_\_\_  Male  Female Student's Birth Date \_\_\_\_\_  
Home Area & Telephone # \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ Town & Zip \_\_\_\_\_  
Child resides with? \_\_\_\_\_ (  Natural  Guardian  Foster )  
Mailing Address (if applicable) \_\_\_\_\_ Town & Zip \_\_\_\_\_  
Father's Name \_\_\_\_\_ Email Address \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Area Code & Phone # \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Email Address \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Area Code & Phone # \_\_\_\_\_

If according to the IEP my child is eligible for special transportation, I  accept  decline special transportation (  AM,  PM,  Both Routes )  
Is your child presently taking prescription medication?  Yes  No If yes, briefly explain: \_\_\_\_\_  
Child's current Height \_\_\_\_\_ Weight \_\_\_\_\_  
List any medical/behavioral concerns that the bus driver should be aware of: \_\_\_\_\_

### EMERGENCY INFORMATION

Please list the names and telephone numbers of TWO relatives or close friends who can pick up or receive your child due to illness, emergency school closing or other emergencies.

#### EMERGENCY CONTACT #1

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone \_\_\_\_\_

#### EMERGENCY CONTACT #2

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone \_\_\_\_\_

I hereby grant authority to Lincoln-Way Special Education personnel to obtain a paramedic to give emergency treatment to my child or obtain ambulance services for my child when it is deemed necessary. I also give permission to the selected paramedic/physician to treat my child as requested by the school in the event I cannot be reached. I am aware that any expenses incurred for any of the above services will not be the responsibility of the resident school district or the Lincoln-Way Area Special Education Joint Agreement District 843.

**I do hereby certify that I am a resident of the above-named school district and that all the information above is true and correct. Please sign and date.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### FOR OFFICE USE ONLY

Date of Program Start \_\_\_\_\_ School Attending \_\_\_\_\_ Program \_\_\_\_\_  
Date Processed and Initials Tyler: \_\_\_\_\_ By: \_\_\_\_\_  
Traversa: \_\_\_\_\_ By: \_\_\_\_\_