

Leakey ISD Pre-Kindergarten Information

To qualify for a state-funded prekindergarten program to be offered by Leakey ISD, please answer the following questions. To have the best opportunity for your child to participate in this program, please answer all questions and return form as soon as possible.

Student Name _____ Date of Birth _____

Parents' Names _____

Physical Address _____

(If over 2 miles from school, will transportation be required?) _____

Mailing Address _____ Home Telephone _____

Parents' e-mail addresses _____

Parent cell numbers _____

State-Required Information:

1. What language does your child speak most of the time? _____
2. What language is spoken in your home most of the time? _____
3. Do you have other children who participate in the free or reduced-price lunch program? _____
If so...their names _____

Would you like to see if you qualify for the free or reduced-price lunch program? _____ If yes, the application is attached. Please submit it as soon as possible.

4. Does the child live with one or both parents? _____ If not, what is your relationship to the child? _____
5. Is a parent currently on active duty in the military? _____ If so, please provide the child's military dependent identification card to the Superintendent for verification.
6. Has the child ever been in foster care? _____

For additional information, please contact Leakey ISD Superintendent, Dr. Barbara Skipper at 830-232-5595.

Please return the form by either scanning and e-mailing OR dropping it by the Superintendent's office (secretary Jan Faulkner). **As Soon As Possible**. Applications will be time and date stamped. Thank you.

LEAKEY ISD Registration Form for School Year 2016 - 2017

Campus Name: LEAKEY ISD

Campus Phone: (830) 232-5595

Campus Fax: (830) 232-5535

STUDENT INFORMATION

Local ID	Student Name	Grade Level	Orig Entry Dt	Track	SSN	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Pacific Islander
						<input type="checkbox"/> White	<input type="checkbox"/> Black
						<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian
Gender	Date of Birth	Birth Place	Age (Sept 1st, 2016)				
Address:					Student Home Phone:		
Mailing Address:					Student Cell Phone:		
Student Email:					Will your child be using bus transportation to get to school? <input type="checkbox"/> Yes <input type="checkbox"/> No		

PARENT INFORMATION

1. Guardian:	Relation:	2. Guardian:	Relation:
Address:		Address:	
City, St, Zip:		City, St, Zip:	
Employer:		Employer:	
Cell Ph:	Home Ph:	Bus Ph:	
Other Ph:	Phone Pref:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Other	
Receive Mailouts:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Language Pref:	<input type="checkbox"/> English <input type="checkbox"/> Spanish
Emergency Contact:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Email:	
Svc Branch:	Rank:	Enrolling Person:	
Right to Transport:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Driver License #:	State:
Vehicle Make:	Model:	Color:	
Vehicle Plate #:	State:		

EMERGENCY CONTACT INFORMATION

1. Name:	Relation:	Cell Ph:	Home Ph:	Bus Ph:
Other Ph:	Phone Pref:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Other	Right to Transport:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vehicle Make:	Model:	Color:	Plate #:	State:
2. Name:	Relation:	Cell Ph:	Home Ph:	Bus Ph:
Other Ph:	Phone Pref:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Other	Right to Transport:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vehicle Make:	Model:	Color:	Plate #:	State:
Doctor:	Bus Ph:	Dentist:	Bus Ph:	
Hospital:	Bus Ph:	Other Medical:	Bus Ph:	
List any Allergies:				

SIBLING INFORMATION

Brothers/Sisters	Grade	School	Brothers/Sisters	Grade	School
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

The above information is required for a permanent school record of your child and will be used by school personnel. Presenting false documents, records or information is a violation of state law and may subject you to tuition cost for your child. I certify that the information given above is correct. I authorize the school to contact the person named on this form and the above named physician to render such treatment as may be necessary in an emergency of said child. In the event parents, physician, or other persons named cannot be contacted, school officials are hereby authorized to take whatever action is necessary in their judgment for the health of the above child. I will not hold the school district financially responsible for emergency care and/or transportation.

Parent or Guardian Signature	Date of Birth	Date
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(For Office Use Only)

Teacher Name:	Control Nbr:	Eligibility Code:
Birth Certificate on File:	Mil Conn:	Foster Care:
Soc Sec Copy on File:	At Risk:	Migrant:
Gift:	LEP:	BIL:
ESL:	Par Per:	Econ:
Special Education:	Prim:	Sec:
Tert:	Multi:	