

# Zion

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## LUTHERAN CHURCH & SCHOOL

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McHenry, IL • 815-385-0859 • [www.zionmchenry.org](http://www.zionmchenry.org)

### School Form Checklist

- Registration Form
- Parent Handbook Acknowledgement
- Parent Volunteer Form
- Emergency Card (yellow)
- Media & Directory Release
- Birth Certificate
- Extended Care Registration Form  
(If using extended care)

### Additional Items required for K – 1st grade

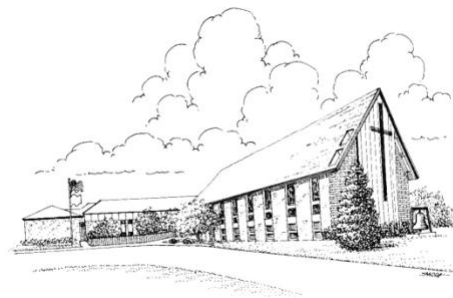
- Medical Form (K & 1<sup>st</sup> grade)
- Dental Form (K)
- Eye Exam Form (K)
- Transportation form  
(If using school bus system)

# Zion Evangelical Lutheran Church and School

4206 West Elm Street • McHenry, IL 60050

(815) 385-4488 • school@zionmchenry.org

www.zionmchenry.org



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## APPLICATION FOR ENROLLMENT

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Appreciating the educational advantages offered by a Christian School, we hereby request that our child be enrolled as a student at Zion Lutheran School.

**INSTRUCTIONS:** All requests need to be filled out completely. This application with the registration fee needs to be returned as soon as possible to ensure your child's enrollment. ***Please note, the registration fee is non-refundable.***

Child's Name: \_\_\_\_\_ Date of Birth & Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

### Class Requested:

\_\_\_\_\_ 2 Half Day Morning Preschool (3yo)  
T Th ~ 9-11:30am

\_\_\_\_\_ 3 Half Day Morning Preschool (4yo)  
M W F ~ 9-11:30am

\_\_\_\_\_ 5 Half Day Afternoon Preschool (4yo)  
M-F ~ 12:30-3pm

\_\_\_\_\_ Full Day Preschool / Pre-K (3-4yo)  
M-F ~ 9am-3pm

\_\_\_\_\_ Half Day Kindergarten  
M-F ~ 9am-12pm  
M-F ~ 12:30-3pm

\_\_\_\_\_ Full Day Kindergarten  
M-F ~ 9am-3pm

\_\_\_\_\_ First Grade  
M-F ~9am-3pm

### Father's Information:

Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

### Mother's Information:

Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Are both parents living at home with this child? \_\_\_\_\_ If no, please give reason: \_\_\_\_\_

If no, who has legal custody of this child? \_\_\_\_\_

Church Member at: \_\_\_\_\_

Baptized: Yes/No Year: \_\_\_\_\_

**Name of person(s) to call if parents cannot be reached:**

\_\_\_\_\_  
Name/Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

\_\_\_\_\_  
Name/Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

In order to help us better understand your child, please list any disabilities or handicaps your child has (*All information is held in the strictest confidence*):

Please list your reasons for wanting your child to be enrolled at Zion Lutheran School:

**NOTE: If your child is being transferred from another school, please answer the following questions. The latest issue of your child's report card must accompany this application.**

School from which you intend to transfer: \_\_\_\_\_

Location: \_\_\_\_\_ Principal: \_\_\_\_\_

Reason for transfer: \_\_\_\_\_

Which grade did he/she last complete: \_\_\_\_\_ When completed: \_\_\_\_\_

Estimate the level of work your child is doing now (circle one): Excellent Good Average Poor

Has your child ever been retained a grade? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Has your child had a speech/language evaluation? Yes No

Has your child been given or recommended for special testing? Yes No

Has your child been recommended for special classes? Yes No

Date of testing: \_\_\_\_\_ Results: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Referred by: \_\_\_\_\_

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

# Zion Lutheran School

## Program Information for the 2018-2019 School Year

CLASSES	REGISTRATION FEE*	MONTHLY TUITION	CHURCH MEMBER TUITION**
<u>2 Day Preschool (3yo)</u> T Th 9:00 - 11:30	\$125	\$150	\$105
<u>3 Day Preschool (4yo)</u> M W F 9:00 – 11:30	\$125	\$225	\$158
<u>5 Day Afternoon Preschool (4yo)</u> 5 Days per week 12:30 – 3:00	\$150	\$275	\$193
<u>Full Day Preschool / Pre-K (3- 4yo)</u> 5 Days per week 9:00 – 3:00	\$225	\$400	\$280
<u>½ Day Kindergarten</u> Morning 9:00 – Noon Afternoon 12:30 – 3:00	\$150	\$275	\$193
<u>Full Day Kindergarten</u> 9:00 – 3:00	\$275	\$400	\$280
<u>First Grade</u> 9:00 – 3:00	\$300	\$400	\$280

**\*The Registration Fee is Non-Refundable and is due at time of registration**

**Tuition is due on the 25<sup>th</sup> of each month for the upcoming month**

**Discounts and Incentives** (Max 1 discount per student)

- There is a 10% discount on each additional student for families
- \*\*Members of Zion receive a 30% discount on tuition. For information about church membership, please contact the Office.
- There is a \$100 referral credit offered following 3rd month of paid tuition

**Additional Services available at Zion Lutheran School**

- **Extended Care program** is available before and after school for at an additional cost:
  - **Option 1:** Mornings: 7:00 - 8:45am **\$12** ~ Afternoons: 3:15- 5:30pm **\$15** (billed weekly)
  - **Option 2:** Unlimited Morning and Afternoon **\$340/month** (billed monthly)
  - **Option 3:** Unlimited Morning **\$160** (billed monthly)
  - **Option 4:** Unlimited Afternoon **\$185** (billed monthly)
- **Bus Service** is available to all enrolled students (5 years old and up) who live within the District 15 School Boundaries

# 2018-19 Zion Lutheran School Extended Care Registration Form

Parent's Name: \_\_\_\_\_

Name of child needing extended care: \_\_\_\_\_

Childs Teacher(s): \_\_\_\_\_ Grade: \_\_\_\_\_

Circle hours when extended care may be needed:

Monday:	Before	After	Tuesday:	Before	After
Wednesday:	Before	After	Thursday:	Before	After
Friday:	Before	After			

Please choose a Payment Option:

**Option 1**

Mornings: 7:00 - 8:45am \$12  
Afternoons: 3:15- 5:30pm \$15  
(billed weekly)

**Option 2**

Unlimited Morning and Afternoon \$340/month (billed monthly)

**Option 3**

Unlimited Morning \$160 (billed monthly)

**Option 4**

Unlimited Afternoon \$185 (billed monthly)

Parents Contact Information

Mother's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any medical conditions, including allergies, that your child has:

Name, relationship and phone number of individuals who are authorized to pick your child up other than parents.

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

I have read Zion Lutheran School's extended care information and understand that I must make bi-weekly, on time, payments in order to keep my child enrolled in the program. **I also understand that I will be assessed a \$10 late charge after 5:30 pm and an additional \$10 after 5:45pm per child if my child(ren) are not picked up, which will be billed on my bi-weekly Extended Care Statement.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**ZION LUTHERAN SCHOOL**  
**PREFERRED PAYMENT METHOD**

**Student Name:** \_\_\_\_\_

My preference for paying invoices from Zion is...

[ ] by **Check or Cash**, mailed or paid in person to the Office.

[ ] by **Credit Card** online or in the office. ***I understand a 3.5% convenience fee will be included in the total amount charged to my card.***

*Invoices are sent the 10<sup>th</sup> of each month for the following month and payment is due by the 25<sup>th</sup> of the month. Tuition rates are based on nine (9) monthly payments.*

# Zion Lutheran School Volunteer form

Zion Lutheran School is continually working to strengthen the partnership between our school and our students' families. Parent involvement is an integral part of your child's education experience. It also provides a fun way to meet other families at Zion.

Listed below are some of the volunteer opportunities available. Please provide us with some information about you and your family's talents and interests. We strive to include all parents and accommodate all schedules and needs. If you see an area that we have missed that you can help us out, please let us know. We appreciate your help!

I am interested in assisting with:

- |  |   |
|--|---|
| <input type="checkbox"/> Laminating                        | <input type="checkbox"/> Occasional help with lunch       |
| <input type="checkbox"/> School Beautification             | <input type="checkbox"/> Fundraisers                      |
| <input type="checkbox"/> Prepare classroom materials       | <input type="checkbox"/> Prepare Scholastic orders        |
| <input type="checkbox"/> Set up or clean up special events | <input type="checkbox"/> Chaperone/drive for field trip   |
| <input type="checkbox"/> Classroom Parent                  | <input type="checkbox"/> Special Classroom activity/party |
| <input type="checkbox"/> Read to Students                  | <input type="checkbox"/> Music                            |
| <input type="checkbox"/> Art                               |   |

I have a talent or skill that I would like to share:

I have access to a resource that might be a great fit for the school:

Parent name:

Student Name:

Email Address:

Phone number:

**PARENT PERSONAL INFORMATION AND MEDIA RELEASE**

**MEDIA**

Throughout the year, many opportunities are present for our teachers and parents to catch some great photos of our students. With your permission, we would like to share these memories with our parents, our congregation, and others to enjoy.

I \_\_\_\_\_ (parent name) understand that throughout the school year, my child (child’s name) \_\_\_\_\_ may be filmed or photographed. I understand that the image may be made available through social media, school advertisements, church website, and other various forms. I agree to allow Zion Lutheran School to publish these photos at their discretion and agree not to hold Zion Lutheran Church liable for harm that may come of unauthorized reproduction.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PERSONAL INFORMATION**

Zion Lutheran School is happy to provide a parent & student directory to those who wish to participate. Parents will receive a directory with a list of student & parents names, address, & any email address or phone number they wish to make available. If you would like to participate in our directory, please fill in the information below.

Parents (or Guardian) Names: \_\_\_\_\_

Child/Children Name(s) & Grade: \_\_\_\_\_

Address: \_\_\_\_\_  
*(Include city, state & zip)*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_



# 2018-19 Zion Lutheran School

August 16, 2018	Open House 5:00 pm - 7:00 pm
August 21, 2018	First Day of School
August 22, 2018	Blessing of the Backpacks (Chapel)
August 23, 2018	Back to school event TBD
August 31, 2018	NO SCHOOL - Teacher In-Service
September 3, 2018	NO SCHOOL - Labor Day
September 13-14, 2018	Mums Sale Pick-Up
September 17-18, 2018**	Picture Days Lifetouch
September 20, 2018	Royal Oak Farm Field Trip
September 23, 2018	Singing in Church 9am & Ice Cream Social
October 8, 2018	NO SCHOOL - Columbus Day
October 28, 2018	Singing in Church 9am & Trunk-or-Treat
November 8 & 9, 2018	NO SCHOOL - Parent / Teacher Conferences
November 12, 2018	Veteran's Day Service
November 19 & 20, 2018	Book Fair
November 20, 2018	Thanksgiving Feast
November 21 - 23, 2018	NO SCHOOL - Thanksgiving Break
November 26, 2018	Classes Resume
December 20, 2018	Christmas Program
December 24 - January 4, 2019	NO SCHOOL - Christmas Break
January 7, 2019	Classes Resume
January 21, 2019	NO SCHOOL - Martin Luther King Day
January 25, 2019	Winter Dance
January 27, 2019	Singing in Church 9am
February 4-10, 2019	Early Enrollment
February 9, 2019	Donuts with Dad
February 11, 2019	Open Enrollment
February 18, 2019	NO SCHOOL - President's Day
February 19, 2019	NO SCHOOL - Teacher In-Service
February 24, 2019	Singing in Church 9am
March 25 -29, 2019	NO SCHOOL - Spring Break
April 1, 2019	Classes Resume
April 12, 2019	Family Fun Night
April 19-22, 2019	Easter Break
April 24-25, 2019	Picture Days Lifetouch
April 26, 2019	NO SCHOOL - Teacher In-Service
April 28, 2019	Singing in Church 9am
May 8-10, 2019	Book Fair
May 10, 2019	Mother's Day Tea
May 23, 2019	Graduation: (Last Full Day of School) T & TH - 10:00 am MWF, Pre-K, K & 1st - 6:00 pm
May 24, 2019	School Picnic - 11:00 am

**Revised 5/31/18**



# McHenry Schools Transportation Department

Districts 15 and 156  
5805 W. Route 120, McHenry, Illinois 60050  
Telephone: (815) 385-6622  
Fax: (815) 363-5070



“Home of the Warriors”  
District 156

## NEW STUDENT (OR) CHANGE OF HOME ADDRESS (OR) DAYCARE NEEDS 2018-2019

**Please fill out information completely ONLY if any of these options apply regarding your child.**

\*Please print all information

Please circle all that apply:

New Student to District 15/156 (or) Address Change (or) Daycare Information

School: \_\_\_\_\_ Grade: \_\_\_\_\_ AM or PM

Today's date: \_\_\_\_\_ Effective date: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Parents Name: \_\_\_\_\_

Previous Home Address: \_\_\_\_\_

New Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male Female

### DAYCARE INFORMATION

Current Daycare Provider's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

New Daycare Provider's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please circle one: Pick up Drop off Pickup & Drop off

**Due to safety reasons a student's pickup stop must be the same five days a week within the student's school boundary. Also a student's drop-off stop must be the same five days a week within the student's school boundary.**

Parent/Guardian Signature: \_\_\_\_\_



State of Illinois  
Certificate of Child Health Examination

Student's Name				Birth Date	Sex	Race/Ethnicity	School/Grade Level/ID#
Last	First	Middle	Month/Day/Year				
Address				Parent/Guardian	Telephone # Home	Work	
Street	City	Zip Code					

**IMMUNIZATIONS:** To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap, Td or Pediatric DT (Check specific type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio (Check specific type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps Rubella																		
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

Comments:

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature	Title	Date
Signature	Title	Date

**ALTERNATIVE PROOF OF IMMUNITY**

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

\*MEASLES (Rubella) MO DA YR \*\*MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease Signature Title

3. Laboratory Evidence of Immunity (check one)  Measles\*  Mumps\*\*  Rubella  Varicella Attach copy of lab result.

\*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.  
\*\*All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: \_\_\_\_\_  
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last			First			Middle			Birth Date <small>Month/Day/Year</small>			Sex	School		Grade Level/ID
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>															
<b>ALLERGIES</b> <small>(Food, drug, insect, other)</small>		Yes	No	List:				<b>MEDICATION</b> <small>(Prescribed or taken on a regular basis.)</small>		Yes	No	List:			
Diagnosis of asthma?		Yes	No	Child wakes during night coughing?				Loss of function of one of paired organs? <small>(eye/ear/kidney/testicle)</small>		Yes	No				
Birth defects?		Yes	No	Developmental delay?				Hospitalizations? <small>When? What for?</small>		Yes	No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain		Yes	No	Diabetes?				Surgery? <small>(List all.) When? What for?</small>		Yes	No				
Head injury/Concussion/Passed out?		Yes	No	Seizures? What are they like?				Serious injury or illness?		Yes	No				
Heart problem/Shortness of breath?		Yes	No	Heart murmur/High blood pressure?				TB skin test positive <small>(past/present)?</small>		Yes*	No	*If yes, refer to local health department.			
Dizziness or chest pain with exercise?		Yes	No	Eye/Vision problems? <small>Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____</small>				TB disease <small>(past or present)?</small>		Yes*	No				
Other concerns? <small>(crossed eye, drooping lids, squinting, difficulty reading)</small>		Yes	No	Bar/Hearing problems?				Tobacco use <small>(type, frequency)?</small>		Yes	No				
Bones/Joint problem/injury/scoliosis?		Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate Other				Alcohol/Drug use?		Yes	No				
<b>PHYSICAL EXAMINATION REQUIREMENTS</b> Entire section below to be completed by MD/DO/APN/PA HEAD CIRCUMFERENCE IF <2-3 years old      HEIGHT      WEIGHT      BMI      B/P															
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance <small>(hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans)</small> Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>															
<b>LEAD RISK QUESTIONNAIRE:</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. <small>(Blood test required if resides in Chicago or high risk zip code.)</small>															
Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date      Result															
<b>TB SKIN OR BLOOD TEST</b> Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> No test needed <input type="checkbox"/> Test performed <input type="checkbox"/> Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____ Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Value _____															
<b>LAB TESTS</b> <small>(Recommended)</small>		Date		Results				Date		Results					
Hemoglobin or Hematocrit				Sickle Cell <small>(when indicated)</small>											
Urinalysis				Developmental Screening Tool											
<b>SYSTEM REVIEW</b>	Normal	Comments/Follow-up/Needs				Normal	Comments/Follow-up/Needs								
Skin						Endocrine									
Ears		Screening Result:				Gastrointestinal									
Eyes		Screening Result:				Genito-Urinary	LMP								
Nose						Neurological									
Throat						Musculoskeletal									
Mouth/Dental						Spinal Exam									
Cardiovascular/HTN						Nutritional status									
Respiratory		<input type="checkbox"/> Diagnosis of Asthma				Mental Health									
Currently Prescribed Asthma Medication:						Other									
<input type="checkbox"/> Quick-relief medication <small>(e.g. Short Acting Beta Agonist)</small>															
<input type="checkbox"/> Controller medication <small>(e.g. inhaled corticosteroid)</small>															
<b>NEEDS/MODIFICATIONS</b> required in the school setting						<b>DIETARY</b> Needs/Restrictions									
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup															
<b>MENTAL HEALTH/OTHER</b> Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal															
<b>EMERGENCY ACTION</b> needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.															
On the basis of the examination on this day, I approve this child's participation in _____ <small>(If No or Modified please attach explanation.)</small>															
<b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> <b>INTERSCHOLASTIC SPORTS</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>															
Print Name			(MD,DO, APN, PA) Signature			Date			Phone			Address			