

DISTRICT 202 SCHOOL INFORMATION FORM

Revised 05/08

For office use only

School: _____ Today's Date: _____ Start Date: _____ ID#: _____ Teacher: _____

Student's Legal Name: _____ Grade: _____
First Middle Last

Name student goes by: _____ SS# _____ Gender: _____ Age: _____
(optional) M or F

Student Address: _____ Subdivision: _____
Number Street City Zip

Home Phone: (____) _____ Birthdate: _____ Birthplace: _____
Month-Day-Year City/State Country (if not USA)

Contact Telephone #'s for Student Attendance:

1st Contact Tel.#: _____ 2nd Contact Tel.#: _____

Ethnic Group (Check all that apply): White _____ Hispanic _____ Black _____ Pacific Island/Asian _____ Amer Indian/Alaskan _____

Student's Native Language: _____ Multi-Racial _____

School Transportation: _____ Before and/or After School Care: _____
Bus/Walk/Car Name of Provider and Phone Number

Student Resides With (at address above):

Family Status: Married _____ Divorced _____ Separated _____ Single _____ Widowed _____ Other _____

ADULT 1 Name: _____ Relationship: _____ Legal Custody: Yes/No

Highest Grade Completed in School: _____ Work: _____
Employer Town Occupation

Work Phone: (____) _____ Cell Phone: (____) _____ Pager: (____) _____

E-Mail Address: _____ Preferred Language for School Written & Electronic Communications _____

ADULT 2 Name: _____ Relationship: _____ Legal Custody: Yes/No

Highest Grade Completed in School: _____ Work: _____
Employer Town Occupation

Work Phone: (____) _____ Cell Phone: (____) _____ Pager: (____) _____

E-Mail Address: _____

Other Parent Student Does Not Reside With: Send Mailings? Yes _____ No _____

ADULT 3 Name: _____ Relationship: _____ Legal Custody: Yes/No

Highest Grade Completed in School: _____ Work: _____
Employer Town Occupation

Work Phone: (____) _____ Cell Phone: (____) _____ Pager: (____) _____

Home Address: _____ Home Phone: (____) _____
Number/Street City/State/Zip

EMERGENCY NAMES: In case parent/guardian cannot be reached, what LOCAL resident(s) may we call?

Name1: _____ Relation to student: _____ Phone: _(____)_____ (H)
Phone: _(____)_____ (Work) Phone: _(____)_____ (Cell)
Name2: _____ Relation to student: _____ Phone: _(____)_____ (H)
Phone: _(____)_____ (Work) Phone: _(____)_____ (Cell)

Previous School Student Attended: _____
Name City-State

Did your student receive special services/programs at their previous school? _____
Speech/TPI/TBE/IEP/Gifted/Title I/Other

Has the student ever attended Plainfield School District in the past? Yes No

SIBLINGS: (Currently attending Plainfield School District 202)

Name _____ School _____ Gender _____ Birthdate _____

Name _____ School _____ Gender _____ Birthdate _____

Name _____ School _____ Gender _____ Birthdate _____

Name _____ School _____ Gender _____ Birthdate _____

Name _____ School _____ Gender _____ Birthdate _____

Name _____ School _____ Gender _____ Birthdate _____

WEARS GLASSES: _____ YES _____ NO

WEARS CONTACT LENSES: _____ YES _____ NO

MEDICAL INFORMATION (Please list any medical conditions we need to know):

It is imperative that all items on this registration form are complete. As parent/guardian of the above named student, I affirm that I have completed this form in its entirety and to the best of my knowledge.

SIGNATURE: _____

DATE: _____

PLAINFIELD SCHOOL DISTRICT 202 - ENROLLMENT FORM

(To be completed by the person with legal custody of the student)

Generally, Illinois law permits only students who are residents of School District 202 to enroll and attend on a tuition-free basis. Under the law, the residence of a student is deemed to be the residence of the person who has legal custody of the student. "If a pupil is determined to be a nonresident of the District for whom tuition is required to be charged pursuant to this section, the School Board shall refuse to permit the pupil to continue attending the schools of the District unless the required tuition is paid for the pupil." "A person who knowingly or willfully presents to any School District any false information regarding the residency of a pupil for the purpose of enabling that pupil to attend any school in that District without the payment of a non-resident tuition charge shall be guilty of a Class C Misdemeanor."

(105 ILCS 5/10-20.12b)

Identifying Information: *(Please print)*

Student:

Person Enrolling Student and Relationship to Student:

(Name)

(Name)

(Relationship)

Current Address:

Current Telephone:

District 202 Address: (If future address is under contract)

District 202 Telephone:

Do you have legal custody of this student? *Yes* *No*

If no, please explain. _____

Residency of Person with Legal Custody of the Student:

As initial proof of residency, the person with legal custody of the student and with whom the student lives in School District 202 must provide at least one or two documents from Category I and at least one or two documents from Category II. (A total of three documents required). *In order to enroll without established residency, proof of future residency as described in Category III along with a \$350.00 deposit is required.* Category I and II documents must be submitted when actual occupancy occurs. If the registering adult claims the student is homeless, Category IV applies.

Category I - PROVIDE AT LEAST ONE OR TWO OF THE FOLLOWING DOCUMENTS:

- _____ The most recent real estate tax bill for my residence showing me as the taxpayer
- _____ Signed lease for my residence
- _____ A closing statement for the purchase of my residence
- _____ Truth in Lending form from closing packet
- _____ Warranty Deed from closing packet
- _____ Completed Student Residency Questionnaire and **notarized** affidavit (owner's proof of residency within District boundaries is required)

Category II - PROVIDE AT LEAST ONE OR TWO OF THE FOLLOWING DOCUMENTS:

- _____ Driver's license
- _____ Library card (If address is printed on card)
- _____ Gas or electric bill
- _____ Public Aid card
- _____ Home/apartment insurance certificate
- _____ Automobile registration
- _____ Other (please specify) _____

Category III - PROVIDE ONE OF THE FOLLOWING DOCUMENTS WITH THE DEPOSIT:

- _____ Fully executed purchase agreement, stating an approximate closing date, and a deposit of \$350.00 is required for nonresidents to prove future residency. An additional tuition payment to cover the next month will be required if occupancy is not acquired within 30 days of the 1st day of school attendance.
- _____ Fully executed residency sales contract, showing no unsatisfied contingencies, and a deposit of \$350.00 will be required for nonresidents to prove future residency. An additional deposit to cover each additional month will be required if occupancy is not acquired within 30 days of the 1st day of school attendance.
- _____ Fully signed lease with occupancy beginning after the 1st day of student attendance and a deposit of \$350.00 will be required for nonresidents to prove future residency. An additional deposit to cover the next month's tuition will be required if occupancy is not acquired within 30 days of the 1st day of student attendance.

Category IV

- _____ None of the documents in Categories I, II, or III above are applicable because the student is homeless and eligible for enrollment under the Illinois Education for Homeless Children Act.

Grounds for Legal Custody: (Check one of the following as applicable. If none is applicable, you must check one of the "Exceptions" noted on the form.)

1. _____ Custody is exercised by a natural or an adoptive parent with whom the student resides.
2. _____ Custody has been granted by court order to a person with whom the student resides for reasons other than to have access to the educational programs of this District. (Attach copy of court order)
3. _____ Custody is exercised under a court approved short-term guardianship. (Attach copy of court order)
4. _____ Custody is exercised by a caretaker adult relative who is receiving aid under the Illinois Public Aid Code for the student who resides with that caretaker for the purposes other than to have access to the educational programs of this District. (Attach copy of Public Aid documents)
5. _____ Custody is exercised by an adult who demonstrates that, in fact, he or she has assumed and exercises legal responsibility for the student and provides the student with a regular fixed nighttime dwelling for purposes other than to have access to the educational programs of this District.

Exceptions:

1. _____ The student is homeless.
2. _____ The student is a foreign exchange student.
3. _____ The student has been placed with a foster parent or child care facility by the Department of Children and Family Services outside this District, but DCFS has determined it to be in the best interests of the student to maintain attendance in this District. (Attach copy of DCFS determination.)
4. _____ The student is at least 18 years old and lives in this District on a full and indefinite length of time basis.
5. _____ The student is under 18, but has been emancipated by court order or marriage and lives in this District on a full and indefinite length of time basis. (Attach copy of court order or marriage license).

Warnings and Affirmation:

Illinois law has made it a crime, punishable by imprisonment and fine, to knowingly or willfully present any false information regarding the residency of a student for purposes of enabling that student to attend on a tuition-free basis or to knowingly enroll or attempt to enroll a student on a tuition-free basis when the student is known to be a non-resident of the District. The School District will seek prosecution to the full extent of the law of any person who the district believes has committed any residency-related crime. Additionally, a civil lawsuit may be initiated by the School District.

I affirm that I am a resident of this District and that the information presented in this Affidavit or in connection with any investigation of my residency or the residency of the student is true, complete, and accurate.

Signature of Person with Legal Custody of the Student

Date

PARENT VIDEO/PHOTO PERMISSION

I give permission to Plainfield School District or its agents, representatives, or employees to videotape or photograph my child during his/her presence and/or participation in the Preschool/Early Childhood Program at the Bonnie McBeth Learning Center. These pictures are used in the classroom.

(Child's Name)

(Parent/Guardian Signature)

(Date)

I give permission to any newspaper publication taking photographs in the school that may involve my child. These pictures could be published in the newspaper.

(Child's Name)

(Parent/Guardian Signature)

(Date)

STUDENT HEALTH HISTORY

To be completed by parent or guardian

STUDENT'S NAME: _____ SCHOOL YEAR: 20____ - 20____

GRADE: ____ BIRTHDATE: _____ SEX: MALE FEMALE SCHOOL: _____

DOCTOR'S NAME: _____ DOCTOR'S PHONE: _____

ALLERGIES YES NO _____

LIFE THREATENING YES NO _____

OTHER YES NO _____

ASTHMA YES NO _____

USES INHALER YES NO _____

BLOOD DISORDERS YES NO _____

DAILY MEDICATIONS YES NO _____

NAMES OF MEDICATIONS _____

Include those taken at home. If taken at school, the medication authorization form must be completed and on file.

DIABETES YES NO _____

EAR/HEARING PROBLEMS YES NO _____

EYE/VISION PROBLEMS YES NO _____

GLASSES/CONTACTS YES NO _____

HEART PROBLEMS YES NO _____

HOSPITALIZATIONS YES NO _____ AGE: _____

MENTAL HEALTH CONCERNS YES NO _____

MUSCULOSKELETAL PROBLEMS YES NO _____

NEUROLOGICAL PROBLEMS YES NO _____

PHYSICAL RESTRICTIONS YES NO _____

SEIZURES YES NO _____

SERIOUS INJURIES YES NO _____ AGE: _____

SURGERY YES NO _____ AGE: _____

Please contact the school nurse if you would like to discuss any medical concerns.
Thank you,

Parent/Guardian Signature

Date



Home Language Survey - Form A

The State of Illinois School Code requires that each school district shall administer a Home Language Survey to each student entering the school district for the first time. The information is used to identify the need for English language support services for your child.

Name of the student: _____
Last First Middle

Date of Birth _____ Country of Birth _____

School: _____ Grade: _____

1. Is a language **other than** English spoken in your home? YES NO
If yes, which language? _____

2. Does your son/daughter speak a language other than English? YES NO
If yes, which language? _____

If the answer to question 1 or 2 is YES, the school will assess your child's English language proficiency. The school will use the W-APT or IPT (PK only) test to measure your child's listening, speaking, reading and writing skills.

3. Has your son/daughter previously attended USA Schools?
 Less than 1 year More than 1 year More than 2 years More than 3 years

4. Has your son/daughter received English as a Second Language (ESL) support services in any previous school district in the USA? YES NO
If 'yes', please indicate name of state and school district _____

Signed: _____
Parent or legal guardian Date

OFFICIAL USE ONLY
District Enrollment Date:
ELL Program Entry Date:

Distribution:
Original/Student cum file

Pink copy to Database Specialist of ELL Program

Yellow copy to TBE/TPI staff

Plainfield Community Consolidated School District 202

*Bonnie McBeth Learning Center
15730 Howard Street
Plainfield, IL 60544
Phone (815) 439-4288*

Dear Parents/Guardians of incoming students,

All preschool students entering District 202 are required to have a preschool physical exam on an Illinois Child Health Exam form, dated after August 25, 2009, listing all dates of required immunizations. This form with up-to-date immunizations must be on file at Bonnie McBeth before school begins in August 2010. This is a District 202 and Illinois Department of Public Health requirement. Children with missing health requirements will not be allowed to start school in August 2010 per District 202 Board of Education policy. It is highly recommended that the physical with up-to-date immunizations be turned in before August 9, 2010.

The Will County Health Department is available for school physicals (\$35), immunizations (\$12.50) and dental exams. Their phone number is 815-727-8670 for physicals and 815-774-7300 for dental exams. They are located at 1106 Neal Ave., Joliet (take I-80 east to Richards St. south and turn left onto Ella Ave then right onto Neal). The new WCHD building is located south of the old building.

Child Health Exam forms, Dental Exam forms, and a list of district nurses and their phone numbers can be accessed on the district website, www.psd202.org homepage by going to services-health. Contact the Bonnie McBeth nurse's office at 815-577-4155 with any questions.

Thank you,

Jessica Mega, RN, Building Nurse
Jennifer Stermer, RN, Certified School Nurse



**STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION**

Please Print

Student's Name			Birth Date			Sex	School			Grade Level /ID#		
Last	First		Middle		Month/Day/ Year							

Address				Parent/Guardian				Telephone #				Work			
Street	City			ZIP code							Home				

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1			2			3			4			5			6			
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																			
Diphtheria and Tetanus (Pediatric DT or Td)																			
Inactivated Polio (IPV)																			
Oral Polio (OPV)																			
Haemophilus influenzae type b (Hib)																			
Hepatitis B (HB)																			
Varicella (Chickenpox)																			Comments
Combined Measles, Mumps and Rubella (MMR)																			
Measles (Rubeola)																			
Rubella (3-day measles)																			
Mumps																			
Pneumococcal (not required for school entry)	<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			
Check specific type (PCV7, PPV23) Date																			
Other (Specify hepatitis A, meningococcal, etc.)																			

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. **Clinical diagnosis is acceptable if verified by physician.** *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. **History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**
Person signing below is verifying 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 Date

3. **Laboratory confirmation (check one)** Measles Mumps Rubella Hepatitis B Varicella
Lab Results Date MO DA YR (Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels														
Date														
Age/Grade	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision														
Hearing														

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Student's Name			Birth Date	Sex	School	Grade Level/ ID #
Last	First	Middle	Month/Day/ Year			

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during the night	Yes Yes	No No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	No
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No
Developmental delay?	Yes	No		Surgery? (List all.) When? What for?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Serious injury or illness?	Yes	No
Diabetes?	Yes	No		TB skin test positive (past/present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No		TB disease (past or present)?	Yes*	No
Seizures? What are they like?	Yes	No		Tobacco use (type, frequency)?	Yes	No
Heart problem/Shortness of breath?	Yes	No		Alcohol/Drug use?	Yes	No
Heart murmur/High blood pressure?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No
Dizziness or chest pain with exercise?	Yes	No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			
Other concerns?			Information may be shared with appropriate personnel for health and educational purposes.			
Ear/Hearing problems?	Yes	No		Parent/Guardian Signature	Date	
Bone/Joint problem/injury/scoliosis?	Yes	No				

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS		HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING 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 (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>					
LEAD RISK QUESTIONNAIRE* Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ Blood Test Result _____ (If child resides in Chicago, blood test is required.)					
TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. Date Read / / Result _____ mm					
LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES		Date	Results	Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin				Endocrine	
Ears				Gastrointestinal	
Eyes	Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/>	Result _____	Genito-Urinary	LMP
		Referred to Ophthalmologist/Optometrist Yes <input type="checkbox"/> No <input type="checkbox"/>		Neurological	
Nose				Musculoskeletal	
Throat				Spinal examination	
Mouth/Dental				Nutritional status	
Cardiovascular/HTN				Mental Health	
Respiratory					
NEEDS/MODIFICATIONS required in the school setting				DIETARY Needs/Restrictions	
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup					
MENTAL HEALTH/OTHER 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					
EMERGENCY ACTION 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			(If No or Modified, please attach explanation.)		
PHYSICAL EDUCATION Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>		INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>			
Physician/Advanced Practice Nurse/Physician Assistant performing examination					
Print Name		Signature		Date	
Address			Phone		

(Complete both sides)

Illinois Department of Public Health PROOF OF SCHOOL DENTAL EXAMINATION FORM



To be completed by the parent (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
				/ /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender:	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Address (of parent/guardian):			

To be completed by dentist:

Oral Health Status (check all that apply)

Yes No **Dental Sealants Present**

Yes No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

Yes No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

Yes No **Soft Tissue Pathology**

Yes No **Malocclusion**

Treatment Needs (check all that apply)

Urgent Treatment — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

Restorative Care — amalgams, composites, crowns, etc.

Preventive Care — sealants, fluoride treatment, prophylaxis

Other — periodontal, orthodontic

Please note _____

Signature of Dentist _____

Date _____

Address _____
Street City ZIP Code

Telephone _____

PLAINFIELD COMMUNITY CONSOLIDATED SCHOOLS

REQUIRED REGISTRATION DOCUMENTS

When registering as a new student to Plainfield School District, the following information will be required:

1. State Board of Education Transfer form if you are currently enrolled in another Illinois school district.
2. Certified Birth Certificate (Please bring the official birth certificate, ***with raised seal***, issued by the county. Wallet-size birth certificates ***must*** include the parents' names, or they will not be accepted)
3. Physical-Must be dated after August 21, 2008 (if entering Preschool, Kindergarten/First, Sixth, Ninth grade, or moving from out of state)
4. Proof of Residency that includes one or two documents from Category A and one or two documents from Category B below (total of 3 document required). All registrations require these documents, even if siblings are already registered in the district.

CATEGORY A-*One or Two of the following:*

- Most recent real estate tax bill showing parent/guardian as the taxpayer
- Signed lease for residence
- Closing Statement/Closing Statement from the purchase of home (must be signed and dated by buyer and seller)
- Settlement Statement (must be signed and dated by buyer and seller)
- Truth in Lending Statement from closing packet (must be signed and dated by buyer and seller)
- Warranty Deed, from closing packet (must be notarized)
- Prepaid hotel receipt
- When Parent/Guardian does not own or lease the residence, a completed Student Residency Questionnaire and Notarized affidavit must be submitted (homeowner's proof of residency within the District boundaries is required).

CATEGORY B-*One or Two of the following:*

- Driver's license
- Utility bill naming you the responsible person at that address
- Homeowner/renter insurance for that address
- Voter Registration Card
- Automobile Registration
- Public Aid Card

If you have any questions, please call the District 202 Registrar's Office for more information at (815) 577-4080.