School:	_		Š.			e Use Only	
Student ID:	_	Expanded Lear	USD ming Programs			ed	
Student Name:	Last Name, First Nam	ne, Middle Initial		Grade:	Birthdate	:	
Address:	City:		Zip:	Zip:		Telephone:	
Siblings attending same school:	Name/Grade		Nan	ne/Grade		Name/Grade	
Parent/Guardian	In Home?	Out of Home?	Home Phone		Work Phone	Cell Phone	
Please Check Ann		Health Information					

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Please Check Appropriate Box		Health Information					
	<u>After School Pick-Up</u> : I (or an approved person I have listed on this application) will pick up my child. I understand that the student must be signed out for accountability purposes.	This information is needed in case your child is injured or becomes ill at school.					
		Name of family physician or medical advisor:					
		Health Plan:					
		MEDICAL ALERT					
	<b><u>Ride the Bus</u></b> : My child will ride the bus home after the program ends.	Health Problems:					
		Allergies:					
		Regular Medication: At home In school In ELP					
		History of Seizures: Yes No					

Persons approved to pick up student from ELP must be 18 years of age, and must show photo identification on pick-up.										
1.	Name:					Telephone:				
2.	Name:									
3.	Name:				Telephone:					
4.	Name:									
5.	Name:									
	Is there	anything else our staff needs	to kno	w about your child?	Additional Information					
	]	Wears glasses/contacts		IEP	Our offerschool Expanded Learning		rogram will be delivered virtually through			
	] Fa	mily situation/court orders		Other:	distance learning and	xpanded Learning Program will be delivered virtually through and subject to change in accordance to Riverside County Department				
	]	Food allergies			of Health guidelines.					