Gardner-South Wilmington Township High School District 73

Registration Form – 2020-21

Phone: 815-237-2176 Fax: 815-237-2842

STUDENT INFORMATION

Student Name:_____ Grade Level:_____
(Last) (First) (MI)

Address:_____ City:_____ Zip:_____
(Street – w/P.O. Box or Apartment Number)

Primary Phone:_____ Date of Birth:_____ Gender: Male Female

Place of Birth: _____
(City) (State) (Country)

Do you currently have a sibling enrolled at GSW, if yes, sibling name:_____

Do you intend to ride the bus this year: YES NO **If Yes, please fill out enclosed bus form**

RACE AND ETHNICITY

These questions are required by the United States Department of Education (72 Fed. Reg. 59267). The first question asks about the student's ethnicity, and the second question asks about the student's race. If a parent/guardian or student age 18 or older declines to respond to either question, the school district is required to provide the missing information by observer identification.

Is the student Hispanic or Latino? (please circle) YES NO

What is the student's race? (please circle ALL that apply)

American Indian/Native Alaskan Asian Black/African-American Native Hawaiian/Pacific Islander White

LANGUAGE SURVEY

Illinois Administrative Code (23 Ill. Admin. Code 228.15) requires that each school district administer a Home Language Survey to each student entering the district for the first time. The information is used to identify the need for English language support services.

Does this student PRIMARILY speak a language OTHER THAN ENGLIGH? (please circle) YES NO

If YES, Please specify the language: _____

Is a language OTHER than English PRIMARILY spoken in your home? (please circle) YES NO

If YES, Please specify the language: _____

Please note: if the answer to either question is YES, the school will assess your student's English language proficiency. As required by Illinois State law, the school will use the WIDA Model or W-APT test to measure the student's listening, speaking, reading and writing skills to determine if he/she needs additional language supports.

PRIMARY FAMILY INFORMATION

Parent/Guardian:_____ Relationship to student:_____

Mailing Address: _____
(Street – w/ PO Box or Apartment Number) (City) (Zip)

Primary Phone:_____ Cell:_____ Work:_____

E-Mail Address: _____

Spouse/Partner:_____ Relationship to student:_____

Primary Phone:_____ Cell:_____ Work:_____

Email:_____

Spouse/Partner: (circle ALL that apply) Web/Records Access Receives Mail Receives Email Can/Pickup
Lives With Disciplinary Contact Primary Care Provider

SECONDARY FAMILY INFORMATION

Parent/Guardian:_____ Relationship to student:_____

Mailing Address: _____
(Street – w/ PO Box or Apartment Number) (City) (Zip)

Primary Phone:_____ Cell:_____ Work:_____

Email:_____

Secondary Family: (circle ALL that apply) Web/Records Access Receives Mail Receives Email Can/Pickup
Lives With Disciplinary Contact Primary Care Provider

EMERGENCY CONTACTS

Emergency Contact Name:_____ Relationship to Student:_____

Primary Phone:_____ Cell:_____ Work:_____

Emergency Contact: (circle ALL that apply) Web/Records Access Receives Mail Receives Email Can/Pickup
Lives With Disciplinary Contact Primary Care Provider

Emergency Contact Name:_____ Relationship to Student:_____

Primary Phone:_____ Cell:_____ Work:_____

Emergency Contact: (circle ALL that apply) Web/Records Access Receives Mail Receives Email Can/Pickup
Lives With Disciplinary Contact Primary Care Provider

Your signature below allows GSW to mail correspondence to your appointed contacts. It will also allow GSW to use emergency contacts in your absence.

Name: _____ Date:_____
(Printed)

Gardner-South Wilmington Township
High School District 73
500 E. Main St. • Gardner, Illinois 60424 • Phone: 815.237.2176 • Fax: 815.237.2842

2020-2021

PROOF OF RESIDENCY FOR ENROLLMENT AND REGISTRATION

Name of Student:_____ Date of Birth:_____

Must provide a copy of 3 documents listed below (1 document from category I and 2 documents from category 2)

Evidence of proof of residency presented:

Category I - must provide a copy of ONE document from category I

[ ] Real Estate Tax Bill
[ ] Signed Lease
[ ] Auto Registration
[ ] An agreement of sale
[ ] Affidavit from local resident attesting registrant is living with the owner at no cost (GSW has form)

AND

Category II – must provide a copy of TWO documents showing proper address from category II

[ ] Driver's license
[ ] Voter registration
[ ] Library Card
[ ] Home/apartment insurance papers
[ ] Gas or electric bill (telephone bill not acceptable)
[ ] Credit Card bill
[ ] Public Aid card
[ ] Other

I cannot provide the required evidence for the following reason(s):_____

By_____ I will provide the following evidence of my residency.

WARNING: If a student is determined to be a non-resident of the District for whom tuition must be charged, the persons enrolling the student are liable for non-resident tuition from the date the student began attending a District school as a non-resident. Parents or guardians making a fraudulent registration will be subject to the payment of retroactive tuition charges for non-resident students, not to exceed 110% of the per capita cost.

A person who knowingly enrolls or attempts to enroll in this School District on a tuition-free basis a student known by that person to be a non-resident of the district is guilty of a Class C misdemeanor, except in very limited situations as defined in State Law (105 ILCS 5/10-20.b(e).

A person who knowingly or willfully presents to the School District any false information regarding the residency of a student for the purpose of enabling that student to attend any school in that district without the payment of a non-resident tuition charge is guilty of a Class C misdemeanor (105 ILCS 5/10-20.12b(f).

I certify that I understand the residency requirements and that I know the penalty for fraudulent registration.

Parent/Guardian Signature:_____ Date:_____

Relationship:_____

Address of Parent/Guardian:_____

Telephone of Parent/Guardian:_____

Gardner-South Wilmington
Township
High School District 73

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Mr. Josh DeLong
Superintendent

Mr. John Engelman
Principal

Dear Parents,

Keeping you informed is a top priority at Gardner-South Wilmington High School. That's why we have adopted the Blackboard Connect Service which will allow us to send a telephone or text message to you providing important information about school events or emergencies. We use Blackboard Connect to notify you of school delays or cancellations due to inclement weather, as well as to remind you about various events, including report card distribution, open house, field trips, and more. In the event of an emergency at school, you can have peace of mind knowing that you will be informed immediately by phone.

What you need to know about receiving calls sent through Blackboard Connect

- Caller ID will display the school's main number when a general announcement is delivered.
- Blackboard Connect will leave a message on any answering machine or voicemail.
- If the Blackboard Connect message stops playing, press any key 1-9 and the message will replay from the beginning.

The successful delivery of information is dependent upon accurate contact information for each student, so please make certain that we have your most current phone numbers. If this information changes during the year, please let us know immediately. If you have any questions, don't hesitate to call.

Name of Student_____ Grade_____

PHONE NUMBERS FOR VOICE-ONLY CALLS

PRIMARY PHONE NUMBER (Do not leave blank--can be cell #)	
ALTERNATE PHONE NUMBER	

CELL PHONE NUMBERS FOR TEXT MESSAGES

PRIMARY CELL NUMBER (Can be same # as primary voice #)	
ALTERNATE CELL NUMBER	
ALTERNATE CELL NUMBER	

Bus Registration Form - GSW

Illinois Central School Bus

2020-2021

Transportation Start Date:_____ Grade:_____

Student Information

Student Last Name	Student First Name
Street Address	City/State/Zip

Parent Information

Custodial Parent #1	Home/Cell Phone Number	Work Phone Number
Custodial Parent #2	Home/Cell Phone Number	Work Phone Number
Step Parent (if living with child)	Home/Cell Phone Number	Work Phone Number

Emergency Information

Name	Home/Cell Phone Number	Work Phone Number
Name	Home/Cell Phone Number	Work Phone Number

Please provide any medical/social information that may be helpful to your child (i.e. bee sting allergies, seizures, motion Sickness, afraid of animals, etc.)

_____

_____

_____ _____

Parent/Guardian Signature Date

Alternate Transportation Request

Students are expected to ride to and from their home unless other arrangements have been authorized through the school. To request an alternate pick-up/drop-off, please complete the bottom portion of this form.

Only TWO bus stop locations per family will be provided.

Location #1 Name	**Location #2** Name
Address	Address
Telephone	Telephone

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2020-2021

Request for Self-Administration of Medication

(NON-Prescription Meds)

Name of Student _____ Date of Birth _____

Address _____ City _____ Zip _____ Phone # _____

I am requesting that the above named student take the following medication during school hours, as needed.

Name of Medication _____

Type of Medication _____
(Tablet, Liquid, Capsule, Inhaler)

Dosage _____ Time(s) to be given _____

I certify that _____ has been instructed in the use and self-administration of _____.
(Name of Medication)

(Parent) _____

He/She understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/She is capable of using this medication independently.

Medication will be kept in the MAIN OFFICE vault inside a medicine cabinet. When needed, the student will come to the main office and take their medication – administered by GSW staff.

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Physician Request for Self-Administration of Medication

If a student is taking a prescription or non-prescription drug during a school day a Physician needs to fill this form out!

Name of Student _____ Date of Birth_____

Address_____ City _____ Zip_____ Phone #_____

The above named student has_____
(Name of Disease or Syndrome)

I am requesting that the above named student take the following medication during school hours.

Name of Medication_____

Type of Medication_____
(Tablet, Liquid, Capsule, Inhaler)

Dosage_____ Time(s) to be given_____

Possible Side Affects_____

I certify that _____ has been instructed in the use and self-

administration of_____.
(Name of Medication)

He/She understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/She is capable of using this medication independently.

I may be reached at the following phone # in the event of a reaction to the medication or emergency:

Name of Physician_____ Phone #_____
(Print)

Physician _____ Date _____
(Sign)

Address of Physician_____ City _____ St.____ Zip_____

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Re: Military Recruiters and Postsecondary Institutions Receiving Student Directory Information

Dear Parents/Guardians:

From time-to-time, military recruiters and postsecondary educational institutions request the names, telephone numbers, and addresses of our secondary students. GSWHS must provide this information unless the parent(s)/guardians(s) request that it not be disclosed without their prior written consent.

IMPORTANT: If you do not want military recruiters or institutions of higher learning to be given your secondary school student's name, address, and telephone number, please complete the form below and return it to the GSW Guidance office. If this form is not returned, we are required to release the student's information.

Sincerely,

Mr. Josh DeLong
Superintendent

To be submitted to Guidance Secretary

Please **do not** release my child's name, telephone numbers, and/or address to:

_____Do NOT release to Military Recruiters

_____Do NOT release to Institutions of higher education – Colleges

(Please do not mark (leave blank) if you DO WANT your student's information released to Military and Colleges)

_____
Student Name (please print)

_____
Parent/Guardian Name (please print)

_____ _____
Parent/Guardian Signature Date

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Armed Forces or Full-time National Guard Survey

A student whose Legal guardian is a member of the Armed Forces or Full-time National Guard on active duty. The terms "Armed Forces," "Active Duty," and "Full-time National Guard duty" have the same meaning as defined in 10 U.S.C. 101(a)(4), 101(d)(1), and 101(d)(5).

- Armed Forces means the Army, Navy, Air Force, Marine Corps, and Coast Guard.

- Active Duty means full-time duty in the active military service of the United States, including full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Such term does not include full-time National Guard duty.

- Full-time National Guard duty means training or other duty, other than inactive duty, performed by a member of the Army National Guard of the United States or the Air National Guard of the United States in the member's status as a member of the National Guard of a State or territory, the Commonwealth of Puerto Rico, or the District of Columbia under section 316, 502, 504, or 505 of title 32 for which the member is entitled to pay from the United States or for which the member has waived pay from the United States.

Is a parent or legal guardian a member of the Armed Forces or Full-time National Guard on active duty. **YES or NO**

Student Name:_____ Grade:_____

Parent/Guardian Name in Military:_____

AUTHORIZATION FOR ACCESS TO DISTRICT TECHNOLOGY SYSTEM BY STUDENTS

This form must be read and signed by each student (and if the under age 18 by his/her parent/guardian) as a condition of using Gardner South-Wilmington Schools' "District Technology System".

By signing this Authorization, I acknowledge that I have received a copy of the "Guidelines for Acceptable Use of District Technology system by Students" and that I have read and understand, and agree to the following Guidelines.

I acknowledge that access to the District technology System is provided as a privilege by the District and that inappropriate use may result in discipline, as may off-site use of electronic technology which disputes or can reasonably be expected to disrupt the school environment.

I ACKNOWLEDGE THAT I HAVE NO EXPECTATION OF PRIVACY IN MY USE OF DISTRICT TECHNOLOGY SYSTEM, AND THAT THE DISTRICT HAS THE RIGHT TO AND DOES MONITOR USE OF THE SYSTEM.

Student Name: _____ Grade: _____

Student Signature: _____

Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

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2020-2021

Publicity Release Form

Your student's image may be photographed, videotaped or otherwise recorded for our schools media usage. These materials include, but are not limited to, photographs of sanctioned activities, souvenir program books, newsletters, newspapers, web pages, yearbook, and invitational, super sectional, and state contest videotapes.

If you have any questions call the School office

_____DO NOT use my student's image as stated above

_____Yes, GSW can use my student's image as stated above

Student Name_____

Parent Name_____

Parent Signature_____Date_____

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

DCFS

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

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 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

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 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 result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																				
Age/ Grade																				
	R	L	R	L	R	L	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 (Last / First / Middle)	Birth Date (Month/Day/Year)	Sex	School	Grade Level/ ID #

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

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE HEIGHT WEIGHT BMI B/P

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONAIRRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionairre Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST 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. **No test needed** ☐ **Test performed** ☐
Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ mm- _____
Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value** _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

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: ☐ Nurse ☐ Teacher ☐ Counselor ☐ 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 ☐ No ☐ 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 ☐ No ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) Yes ☐ No ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

State of Illinois
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: ☐ Male ☐ 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 of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

IOCI 0600-10 Printed by Authority of the State of Illinois

_____

GARDNER-SOUTH WILMINGTON
HIGH SCHOOL DISTRICT NO. 73
500 EAST MAIN ST.
GARDNER, IL 60424

2020-2021

Fees: $25.00 for entire year
$12.50 – after Winter Break
$10.00 – after Spring Break

Vehicle Registration

The following information, along with payment MUST be turned into the front office prior to receiving a parking space. There will be NO "saving spots" – you must have a valid driver's license in order to purchase a parking spot on GSW HS property. Please photocopy the required documents and attach them to the completed form. If at any time you need to drive a different vehicle to school you must report the required information to the school office.

Need COPIES of the following items:

- ☐ A valid drivers license
- ☐ Current Insurance Card
- ☐ Current Vehicle Registration Form

Students Name_____

Address_____ City_____ Zip_____ Phone #_____

Make & Year of Vehicle_____ Color of Vehicle_____

License Plate #_____

I have read the above information and the GSW Vehicle Regulations and agree to assist my son/daughter in abiding by the regulations.

Parent's Name_____
Print

Parent's Signature_____ Date_____

I have read the above information and the GSW Vehicle Regulations and will abide by the regulations.

Student's Signature_____ Date_____

Assigned Parking Space # _____