Office Use Only

____Enrolled ____/____/____

____Paid_____

HIGHLAND PARK INDEPENDENT SCHOOL DISTRICT
The Academy for Lifelong Learning
2026-2027 EXTENDED SCHOOL DAY PROGRAM
6915 Westchester, Dallas, Texas 75205 214-780-3380

Please Return Completed form to A.L.L. Office

Student ID:

STUDENT INFORMATION

Last Name_____ First Name_____ Middle Name_____

Preferred Name_____ Birth Date_____ Sex_____

School_____ Grade (as of Sept.1, 2026) _____Age (as of Sept.1, 2026) _____

Student Enrolled in ESL (English as Second Language)? Yes, ____ No, ____

Home Address_____ Dallas, Texas_____(zip)

Home Phone_____ Parent Cell Phone _____

PARENT INFORMATION

Parent One:

Last Name _____ First Name_____

Address (if different from child)

_____

Employer_____Occupation_____

Work Phone_____ Cell Phone_____ E-mail _____

Parent Two:

Last Name _____First Name_____

Address (if different from child)

_____

Employer_____Occupation_____

Work Phone_____ Cell Phone_____ E-mail_____

With whom does the student live? _____

Which parent should we call in an emergency? _____

List individuals authorized by a parent/ guardian who may pick up the student or we can call if parents are unavailable. These individuals may need to show a driver's license for identification purposes. Changes to the list MUST be in writing for the A.L.L. office. *****YOU ARE REQUIRED TO LIST AT LEAST 2 NAMES***

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Student Name _____ School _____ Grade_____

Please list any other information about your child, including persons who may NOT pick up your child. If the person is a natural parent of the child, official court/custody papers MUST be on file in the A.L.L. office.

_____

_____

_____

HEALTH INFORMATION

Student's doctor _____ Phone _____

Hospital preference _____

Student's dentist_____ Phone _____

Please check if applicable:

Attention Deficit Disorder/Hyperactivity_____ Asthma_____ Diabetes_____ Heart Condition ____ Seizure Disorder____

Other health conditions or disabilities_____

Allergies_____

Recommended treatment if allergy is severe _____

Parent must provide Epi-pen if needed for treatment. **Date provided**: _____

Medications and times administered_____

Vision or hearing problems_____

Accommodations/modifications received through ADA or special education _____

_____

Please note any added concerns of which the teachers should be aware_____

_____

By completing and signing this form, I agree and understand that:

- I release Highland Park Independent School District and its' employees from liability in case of an accident.
- I give permission to ESD staff to provide emergency medical care for my child if needed. I understand that I am financially responsible for any expenses for medical care or transport incurred on my child's behalf.
- I will keep my financial obligations to the program concerning tuition and fees.
- I have read and agree to abide by the Guidelines of the ESD program.

_____ _____ _____

Signature of Parent or Guardian | Printed Name | Date