



**Kankakee Area
Special Education
Cooperative**

**Extended School Year
Enrollment Form
2009**

Student name: _____

District of residence: _____ Date of birth: _____ Grade: _____

Medicaid eligible: YES NO Medicaid number: _____

Parent/Guardian name: _____

Address: _____

Telephone: _____ Cell phone: _____

Emergency contact: _____ Telephone: _____

Service	Minutes per week	Length of session *# of days, weeks, etc.	Location *Include address
Vision Itinerant			
Occupational Therapy			
Physical Therapy			

****IEP goals/objectives must be attached.**

District Superintendent/Designee Signature: _____

Parent/Guardian Signature: _____

KASEC Admin./Service Provider Signature: _____