UNITED SCHOOLS NETWORK

UNITE TODAY. CHANGE TOMORROW.

Enrollment Form: 2017 – 2018 School Year

EXCELLENCE
CULTURE
COMMITMENT
PASSION
INTEGRITY

Please submit with this application the following documents:

□ Copy of Student's Birth Certificate □ Copy of Immunization Records

□ Proof of Residence (utility bill or lease) □ Copy of Guardian's State I.D.

Students will NOT be fully enrolled until all documents are received by the admissions office.

DATE OF APPLICATION: _____ (MM/DD/YYYY)

Campus: ☐ United Preparatory Academy - State ☐ United Preparatory Academy - Main

STUDENT INFORMATION

Student Name (First) (Middle) (Last)

Gender: ☐ Male ☐ Female **Birthdate**: _____ (MM/DD/YYYY)

City of Birth : _____ **Primary Language Spoken at Home**: _____

2017-2018 Grade: _____ **("Home") School District**: _____

Name of Current School: _____

Home Address (Street Number) (Street Name) (Apartment/Unit #)

(City) (State, Zip Code)

The collection of student demographic information is required by Federal regulation.

Ethnic Origin: ___ Asian ___American Indian/Alaskan Native ___Black/African American (Non-Hispanic)

___Hispanic/Latino ___ Multi-Racial ___Pacific Islander ___White (Non-Hispanic)

Please note that your response to the questions below will NOT affect your student's enrollment opportunity. Rather the collection of this data will help to ensure that we can provide the best possible support for your student.

Yes	No	
☐	☐	Does the student currently receive **Special Education services under an Individualized Education Plan (IEP/504 Plan)**? (If checked **"Yes"** please provide documentation to the admissions office)
☐	☐	Is the student currently under a disciplinary action from their current school (suspension/expulsion)?
☐	☐	Is the student a brother or sister of a current Columbus Collegiate Academy or United Preparatory Academy student? If yes, please print the sibling's name: _____

PARENT INFORMATION

Parent/Guardian Name (First) (Middle) (Last)

Email Address (If Applicable) **Relationship to Student**

Home Address (Street Number) (Street Name) (Apartment/Unit #)

(City) (State, Zip Code)

( ) - ( ) -

Home Telephone Number ☐ **Primary** **Cellular Telephone Number** ☐ **Primary**

Parent/Guardian Name (First) (Middle) (Last)

Email Address (If Applicable) **Relationship to Student**

Home Address (Street Number) (Street Name) (Apartment/Unit #)

(City) (State, Zip Code)

( ) - ( ) -

Home Telephone Number ☐ **Primary** **Cellular Telephone Number** ☐ **Primary**

Home Status

Student lives with: ☐ **Mother** ☐ **Father** ☐ **Both** ☐ **Other please specify:** _____

In the case of primary custody, who is the residential parent? _____
Provide custodial document to verify

To whom should school correspondence be sent? ☐ **Mother** ☐ **Father** ☐ **Both** ☐ **Legal Guardian**

How did you hear about us? **___Community Partnership ___Community Event ___ Door-to-Door ___ Family/Friend ___ Letter ___Postcard ___Phone Call ___Pre-K/Headstart ___Other: _____**

REFER A FRIEND! If they enroll, you will get a FREE UNIFORM SHIRT!

Name: _____ **Approximate age of student:____**

Contact Info:_____

MEDICAL INFORMATION: Please read p. 4 of this packet before signing.

Does your child have a medical condition that will require assistance at school? ☐ **Yes** ☐ **No**

*If yes, complete p. 4-6 of this packet

Will your child require prescription medication during school hours? ☐ **Yes** ☐ **No**

*If yes, your health care provider must complete a **Medication Form**.

Does your child have any allergies? ☐ **Yes** ☐ **No**

*If yes, complete p.4 of this packet

I give permission to share my child's health information with school staff. ☐ **Yes** ☐ **No**

Primary Care Physician Name	**Phone #** ( ) -
Dentist Name	**Phone #** ( ) -
Local Hospital Name	**Phone #**

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist and the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery are obtained prior to the performance of surgery.

Check a box: □ I agree to these terms □ I DO NOT agree to these terms

If you DO NOT agree to the terms above, state below the actions you wish school authorities to take in case of an illness or injury requiring the emergency treatment of your student :

/ /

Signature **Date**

EMERGENCY CONTACT INFORMATION: Please provide contact information for at least one individual in case we are unable to reach you.

1	( ) -	
Name (First Last)	**Phone #**	□ **Check box if authorized to pick-up/drop-off**
2	( ) -	
Name (First Last)	**Phone #**	□ **Check box if authorized to pick-up/drop-off**

ADULTS AUTHORIZED TO PICK CHILD UP FROM SCHOOL: Please provide contact information for individuals not listed above.

		( ) -
Name (First Last)	**Relationship to Student**	**Phone #** ( ) -
Name (First Last)	**Relationship to Student**	**Phone #** ( ) -
Name (First Last)	**Relationship to Student**	**Phone #**

ADULTS NOT AUTHORIZED TO PICK CHILD UP FROM SCHOOL

		( ) -
Name (First Last)	**Relationship to Student**	**Phone #** ( ) -
Name (First Last)	**Relationship to Student**	**Phone #** ( ) -
Name (First Last)	**Relationship to Student**	**Phone #**

MEDIA RELEASE AUTHORIZATION (*Read p. 7 of this packet prior to signing.)*				
I agree to the terms of the Media Release Form located on p. 7 of this packet.	**| |**	**Yes**	**| |**	**No**
/ /				
Signature **Date**				
RELEASE STATEMENT FOR STUDENT INFORMATION: LEARNING CIRCLE EDUCATION SERVICES (Read p. 7)				
I agree to the terms of the release statement for student information on p. 7 of this packet		**Yes**		**No**
/ /				
Signature **Date**				

HEALTH INFORMATION INVENTORY

Transported by School Bus □ Yes □ No

Your child's learning depends upon good health. Please complete this form with information you are comfortable sharing. Health conditions currently affecting your child are of the greatest significance.

Allergies? □ Yes □ No

List the medications or seasonal/environmental conditions that your child is allergic to.

Please list _____

Has the allergy required emergency care in the past? □ Yes □ No

Comments _____

Bee Sting Allergy? □ Yes □ No

Describe reaction _____

Emergency medication? □ Yes □ No

Please list the medication and how it is administered.

_____

Peanut Allergy? □ Yes □ No

Describe reaction _____

Emergency medication? □ Yes □ No

Do you eliminate all peanut-containing foods? Yes No

Comments_____

Other Food Allergy? □ Yes □ No

Food(s) _____

Describe reaction _____

Need emergency medication? □ Yes □ No

Asthma? □ Yes □ No Triggered by: _____

Treatment _____

Diagnosed by doctor: _____ Date _____

Diabetes? □ Yes □ No Date diagnosed _____ Type I ___ Type II ___

Takes insulin? □ Yes □ No **Insulin Pump?** □ Yes □ No

Insulin Injection? □ Yes □ No **Insulin Pen?** □ Yes □ No

Epilepsy/Seizures ? □ Yes □ No

Describe seizure_____

Date of last seizure _____

Medication _____

Is student currently under a doctor's care for seizures? □ Yes □ No

Heart Condition? □ Yes □ No

Describe_____

Activity restrictions? _____

Skeletal Problem ? □ Yes □ No **Describe** _____

Activity restrictions? _____

Please check the box next to the following health conditions that pertain to student:

Eyes/Vision	Ears/Hearing	Other	Other
□ Glasses	□ Frequent Ear Infections	□ ADD/ADHD	□ Sleeping
□ Contacts	□ Hearing aid (left or right)	□ Anxiety	□ Skin Rashes/Lesions
□ Amblyopia	□ Tubes	□ Bi-Polar	□ Eating Disorder
□ Estropia	□	□ OCD	□ Eating Disorder
□ Frequent Infections	□	□ ODD	□ Requires Diapers
□	□	□ Bladder	□ Bowel
□	□	□ Special Diet	□ Breathing
□	□	□ Dental	□ Menstruation
□	□	□ Neurological	□ Nosebleeds
□	□	□ Phobias	□ Sickle Cell Anemia

List serious injury, illness or syndrome: _____

Surgeries (operations): _____

Condition that prevents or limits Physical Education (P.E.) participation: _____

Requires special health care? Explain _____

Other health information or concerns: _____

MEDICAL INFORMATION

Dear Parent/Guardian:

Thank you for completing your child's Student Emergency/Medical Information.

If you indicated that your child has a medical condition(s) and this medical condition requires attention/assistance we ask that you:

- Have your child's health care provider complete and sign the attached document
- Complete and sign the parent/guardian sections of the attached document
- Provide an Emergency Care Plan and Medication Form (if indicated)
- Please return the signed forms to the school's front office.

Please be advised that:

- **No medication will be administered or can be self-administered at school without a Medication Administration Form completed and signed by your child's health care provider and you.**
- One Medication Administration Form is needed for each medication.
- The medication must be delivered to the school in a pharmacy labeled container with clear instructions.

The medical information will be shared only with school staff with a need to know to help ensure your child's health/safety.

MEDIA RELEASE FORM

Dear Parent/Guardian:

On occasion, representatives from the media wish to photograph, videotape, and/or interview students in connection with school programs or events. Educating the public is one of our objectives. The entire community benefits from knowing about the needs and abilities of our students and about the programs we offer to children and families. In order to release student photos, video footage, comments and/or post on the county website, we need written permission. Please indicate your decision and sign the Media Release Form section of this packet (p. 3).

I give permission for my child to be photographed, videotaped, and/or interviewed by representatives from the media for the purpose of publicizing educational programs. I authorize the use and reproduction by United Preparatory Academy or anyone authorized by the United Preparatory Academy Board of any and all photographs and/or videotapes taken of my child, without compensation to me/my child. All of these photographs/video recordings shall be the property, solely and completely, of the United Preparatory Academy. I waive any right to inspect or approve the finished photographs/videotapes, and the sound track, script or printed matter that may be used in conjunction with them.

RELEASE STATEMENT: LEARNING CIRCLE

I hereby grant permission for the school to share my child's program information (name, date of birth, student ID) with Learning Circle Education Services. I understand that information will only be shared about my child if it is relevant to my child's education. The community program may also request access to my child's academic, attendance and behavior records at the school so that they can provide better services to my child. I understand that this information will be kept confidential.

UNITED SCHOOLS NETWORK

UNITED PREPARATORY ACADEMY

Request for Permanent Records

2017-2018 School Year

_____ has enrolled in United Preparatory Academy and the student's first day will be _____.

Please send the following information to:

United Preparatory Academy
Attn: Operations Staff
617 West State Street
Columbus, Ohio 43215
Ph: 614.453.8993
Fax: 614.375.1337

Cumulative Records	Special Education (IEP/ETR)	Copy of Student's Data Form
Physician's Record	Grade Card	Immunization Record
Dental Record	Birth Certificate	OAA Results
Expulsion/Suspension Documents		

Name of School Child Last Attended	
School District	
School Address	
City, Zip Code	
Last Grade Attended	PreK K 1 2 3 4

In accordance with the Family Educational Rights and Privacy Act dated June 17, 1976, parental permission is no longer required when records are requested by authorized school personnel.

Signature of Parent/Guardian:_____
Date: _____

Thank You,
Operations Manager
United Preparatory Academy