UNITED SCHOOLS NETWORK

UNITE TODAY. CHANGE TOMORROW.

ENROLLMENT PACKET

2017-2018 SCHOOL YEAR

DATE OF APPLICATION: _____

**** Students are NOT considered fully enrolled until all required documentation is received by the Admissions Office ****
With this packet and Intent to Enroll Form, please submit copies of the following:

☐ Birth Certificate ☐ Immunization Records ☐ Parent/Guardian Photo I.D. ☐ Proof of Residency

Campus ☐ Columbus Collegiate Academy – Main ☐ Columbus Collegiate Academy – Dana

STUDENT INFORMATION				
Student Name	First	Middle	Last	
PARENT/GUARDIAN INFORMATION – Individual completing this form				
Parent/Guardian Name	First	Middle	Last	
EMERGENCY CONTACT INFORMATION – Provide information for at least one individual besides yourself.				
1				☐ *Yes* ☐ *No*
Name		**Relationship**	**Phone #**	**Authorized to Pick-up?**
2				☐ *Yes* ☐ *No*
Name		**Relationship**	**Phone #**	**Authorized to Pick-up?**
AUTHORIZED ADULTS TO PICK STUDENT UP FROM SCHOOL – Other than emergency contacts				
Name	First	Last	**Phone #**	**Relationship to Student**
Name	First	Last	**Phone #**	**Relationship to Student**
Name	First	Last	**Phone #**	**Relationship to Student**
UNAUTHORIZED ADULTS TO PICK CHILD UP FROM SCHOOL – If applicable				
Name	First	Last	**Phone #**	**Relationship to Student**
Name	First	Last	**Phone #**	**Relationship to Student**
Name	First	Last	**Phone #**	**Relationship to Student**
MEDICAL INFORMATION – Read page 3 of Enrollment Packet before signing.				
Does your student have a medical condition that will require assistance at school? ☐ *Yes* ☐ *No*				
**** If yes, complete page 4-5 of this packet ****				
Will your student require prescription medication during school hours? ☐ *Yes* ☐ *No*				
**** If yes, your healthcare provider MUST complete Medication Form from Admissions Office ****				

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

**** If yes, complete page 4 of this packet ****

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

DOCTOR INFORMATION

Primary Care Physician Name	First	Last	**Phone #**
Dentist Name	First	Last	**Phone #**
Local Hospital Name	Address		**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 one (1) box: ☐ *I agree to the terms* ☐ *I do NOT agree to the terms*

*** If you do NOT agree to the terms above, state here the actions you wish school administration to take in case of an illness or injury requiring emergency treatment of your student:*

Signature	**Date**

MEDIA RELEASE AUTHORIZATION – Read page 6 of Enrollment Packet before signing.

☐ *Yes* ☐ *No*

"I agree to the terms"	**Signature**	**Date**

HELATH CLASS PARTICIPATION AUTHORIZATION – Read page 6 of Enrollment Packet before signing.

☐ *Yes* ☐ *No*

"I agree to the terms"	**Signature**	**Date**

RELEASE STATEMENT: LEARNING CIRCLE – Read page 7 of Enrollment Packet before signing.

☐ *Yes* ☐ *No*

"I agree to the terms"	**Signature**	**Date**

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
- Provide an Emergency Care Plan and Medication Form (if indicated).
- 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.

HEALTH INFORMATION INVENTORY

Your student's learning depends on good health. Please complete this form with information you are comfortable sharing. Health conditions currently affecting your student 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 required? ☐ Yes ☐ No

Please list the medication and how it is administered _____

Peanut Allergy? ☐ Yes ☐ No

Describe reaction _____

Emergency medication required? ☐ Yes ☐ No

Do you eliminate all peanut-containing foods? ☐ Yes ☐ No

Comments _____

Other Food Allergy? ☐ Yes ☐ No

Food(s) _____

Describe reaction _____

Emergency medication required? ☐ 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 (cont.)		Other (cont.)	
☐	Glasses	☐	Frequent Ear Infections	☐	OCD	☐	Sickle Cell
☐	Contacts	☐	Hearing aid	☐	ODD	☐	Skin Rashes/Lesions
☐	Amblyopia	☐	Tubes	☐	Bladder	☐	Nosebleeds
☐	Estropia	☐		☐	Special Diet	☐	Eating Disorder
☐	Frequent Infections	Other		☐	Dental	☐	Requires Diapers
☐		☐	ADD/ADHD	☐	Neurological	☐	Bowel
☐		☐	Anxiety	☐	Phobias	☐	Breathing
☐		☐	Bi-Polar	☐	Sleeping	☐	Menstruation

List serious injury, illness or syndrome _____

Surgeries or operations _____

Condition that prevents or limits Physical Education (gym) participation _____

Requires special health care? Explain _____

Other health information or concerns _____

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. 1).

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 Columbus Collegiate Academy or anyone authorized by the Columbus Collegiate 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 Columbus Collegiate 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.

HEALTH CLASS PERMISSION

Dear Parent/Guardian:

Columbus Collegiate Academy teaches health classes throughout the course of the year. The classes are intended to promote healthy, responsible choices for students by providing them information about health topics, teaching them skills such as decision-making and media literacy, and by encouraging them to discuss their health concerns with their parents and qualified health professionals.

Sexual health education may be a part of some of these sessions. We believe that this is an important component of the program, but parents have the right to exempt their child from the health classes that discuss sexuality. Alternative learning activities will be provided for students whose parents choose to exempt their student from those particular classes. To give your consent, please indicate so and sign the Health Class Participation Authorization section of this form (p. 2). Please note that we ask parents to state whether they do or do not want to have their child participate in the classes that deal with sexual health.

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.

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UNITED SCHOOLS NETWORK
COLUMBUS COLLEGIATE ACADEMY
MAIN

RECORDS REQUEST

2017-2018 SCHOOL YEAR

_____ intends to enroll in CCA-Main (IRN 009122), and his/her projected first day of school is August 23, 2017.

Please send the listed documents to:

Email: admissions.ccamain@unitedschoolsnetwork.org

Fax: 614-299-5303

Mail: Columbus Collegiate Academy - Main
Attn: Operations Staff
1469 East Main Street
Columbus, OH 43205

For questions regarding the student's enrollment or this request for permanent records, please call the main office at 614-299-5284.

- ☐ Attendance Records
- ☐ Birth Certificate
- ☐ Cumulative Records
- ☐ Disciplinary Records (Suspension, Expulsion)
- ☐ ELL/LEP Score Results
- ☐ Grade Cards
- ☐ Immunization Records
- ☐ Physician and Dental Records
- ☐ Special Education (ETR, IEP, 504 Plan)
- ☐ State Testing Results (OAA, PARCC, AIR)
- ☐ Student State Identification (SSID)

Name of current/last school attended _____

School district _____

Last grade attended _____ Birthdate _____

NOTE: 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.

Parent/guardian signature _____ Date _____