



# ENROLLMENT PACKET

UNITED SCHOOLS NETWORK

2017-2018 SCHOOL YEAR

UNITE TODAY. CHANGE TOMORROW.

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

<b>Student Name</b>	First	Middle	Last
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## PARENT/GUARDIAN INFORMATION – Individual completing this form

<b>Parent/Guardian Name</b>	First	Middle	Last
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## EMERGENCY CONTACT INFORMATION – Provide information for at least one individual besides yourself.

1		<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>Name</b>	<b>Relationship</b>	<b>Phone #</b>	<b>Authorized to Pick-up?</b>
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2		<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>Name</b>	<b>Relationship</b>	<b>Phone #</b>	<b>Authorized to Pick-up?</b>
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## AUTHORIZED ADULTS TO PICK STUDENT UP FROM SCHOOL – Other than emergency contacts

<b>Name</b>	First	Last	<b>Phone #</b>	<b>Relationship to Student</b>
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<b>Name</b>	First	Last	<b>Phone #</b>	<b>Relationship to Student</b>
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<b>Name</b>	First	Last	<b>Phone #</b>	<b>Relationship to Student</b>
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## UNAUTHORIZED ADULTS TO PICK CHILD UP FROM SCHOOL – If applicable

<b>Name</b>	First	Last	<b>Phone #</b>	<b>Relationship to Student</b>
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<b>Name</b>	First	Last	<b>Phone #</b>	<b>Relationship to Student</b>
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<b>Name</b>	First	Last	<b>Phone #</b>	<b>Relationship to Student</b>
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## 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>*** If yes, complete page 4 of this packet ***</i>			
I give permission to share my child's health information with school staff?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>DOCTOR INFORMATION</b>			
<b>Primary Care Physician Name</b>	First	Last	<b>Phone #</b>
<b>Dentist Name</b>	First	Last	<b>Phone #</b>
<b>Local Hospital Name</b>	Address		<b>Phone #</b>
<p>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.</p>			
<p><b>Check one (1) box:</b>                      <input type="checkbox"/> <i>I agree to the terms</i>                      <input type="checkbox"/> <i>I do NOT agree to the terms</i></p>			
<p><i>** 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:</i></p>			
<b>Signature</b>		<b>Date</b>	
<b>MEDIA RELEASE AUTHORIZATION – Read page 6 of Enrollment Packet before signing.</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>"I agree to the terms"</b>		<b>Signature</b>	<b>Date</b>
<b>HEALTH CLASS PARTICIPATION AUTHORIZATION – Read page 6 of Enrollment Packet before signing.</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>"I agree to the terms"</b>		<b>Signature</b>	<b>Date</b>
<b>RELEASE STATEMENT: LEARNING CIRCLE – Read page 6 of Enrollment Packet before signing.</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>"I agree to the terms"</b>		<b>Signature</b>	<b>Date</b>

**UNITED SCHOOLS NETWORK | [www.unitedschoolsnetwork.org](http://www.unitedschoolsnetwork.org)**

**Columbus Collegiate Academy – Main** | Grades 6-8 | 1469 East Main Street, Columbus, OH 43205 | Ph: 614-557-0116  
**Columbus Collegiate Academy – Dana** | Grades 6-8 | 300 Dana Avenue, Columbus, OH 43223 | Ph: 614-381-7009  
**United Preparatory Academy – State** | Grades K-4 | 617 West State Street, Columbus, OH 43215 | Ph: 614-381-7188  
**United Preparatory Academy – Main** | Grade K | 1469 East Main Street, Columbus, OH 43205 | Ph: 614-557-3574

# 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     NoDate diagnosed \_\_\_\_\_     Type I     Type IITakes insulin?     Yes     No    Insulin Pump?     Yes     NoInsulin 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.)	
<input type="checkbox"/>	Glasses	<input type="checkbox"/>	Frequent Ear Infections	<input type="checkbox"/>	OCD	<input type="checkbox"/>	Sickle Cell
<input type="checkbox"/>	Contacts	<input type="checkbox"/>	Hearing aid	<input type="checkbox"/>	ODD	<input type="checkbox"/>	Skin Rashes/Lesions
<input type="checkbox"/>	Amblyopia	<input type="checkbox"/>	Tubes	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	Estropia	<input type="checkbox"/>		<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	Eating Disorder
<input type="checkbox"/>	Frequent Infections	<b>Other</b>		<input type="checkbox"/>	Dental	<input type="checkbox"/>	Requires Diapers
<input type="checkbox"/>		<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	Bowel
<input type="checkbox"/>		<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Phobias	<input type="checkbox"/>	Breathing
<input type="checkbox"/>		<input type="checkbox"/>	Bi-Polar	<input type="checkbox"/>	Sleeping	<input type="checkbox"/>	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**

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. 2).

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 CCA or anyone authorized by the CCA 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 CCA. 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.

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## **HEALTH CLASS PERMISSION**

CCA 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.

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## **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.

# HOUSEHOLD INFORMATION FORM

Columbus Collegiate Academy - Dana is participating in the Community Eligibility Provision under the National School Lunch Program. Under this option, all children in the school will receive a breakfast and lunch at no charge regardless of completion of this form. However, to determine eligibility for various additional state and federal program benefits for which your child's school may qualify, please complete this form if your income falls within or below the guidelines listed in the following chart.

**INCOME GUIDELINES – 185%**  
**Guidelines to be effective from July 1, 2017 through June 30, 2018**

Persons in Family or Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	\$21,590	\$1,800	\$900	\$831	\$416
2	29,101	2,426	1,213	1,120	560
3	36,612	3,051	1,526	1,409	705
4	44,123	3,677	1,839	1,698	849
5	51,634	4,303	2,152	1,986	993
6	59,145	4,929	2,465	2,275	1,138
7	66,656	5,555	2,778	2,564	1,282
8	74,167	6,181	3,091	2,853	1,427
Each Additional Member Add	+7,511	+626	+313	+289	+145

If any member of your household receives Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) or Ohio Works First (OWF) benefits, provide the name and 10-digit case number for the person who receives the benefits then proceed to Section 4 (Signature) on the next page. If no one receives these benefits, start with Section 1 (Size of Family).

Name \_\_\_\_\_ 10-Digit Case Number \_\_\_\_\_

**INSTRUCTIONS** - These selections must be completed by the Head of Household or Designee

- 1. SIZE OF FAMILY** - Indicate total individuals living in household, including adults and children: \_\_\_\_\_
- 2. STUDENT INFORMATION** - Complete for each student Pre-K through 12<sup>th</sup> grade

Last Name	First Name	Birth Date MM-DD-YY	School	Identify H if Homeless M if Migrant R if Runaway F if Foster
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

\* If you need additional lines, attach a second sheet to this survey or attach a copy of this survey clearly marked as "Page 2"

- 3. TOTAL MONTHLY HOUSEHOLD INCOME** – Report Income for all members of household excluding foster children. If you have reported a case number on previous page, you do not need to complete this section.

Type of Income	Income	Circle if No Income
1. Gross Monthly Earnings: Wages, Salary, Commissions	\$	None
2. Monthly Welfare Payments, Child Support, Alimony	\$	None
3. Monthly Payments from Pensions, Retirement, Social Security	\$	None
4. Monthly Dividends or Interest on Savings	\$	None
5. Monthly Worker’s Compensation, Unemployment, Strike Benefit	\$	None
6. Other Monthly Income (SSI, VA, Disability, Farm, other)	\$	None
<b>7. Total Monthly Household Income</b> (Add lines 1-6)	\$	

- 4. SIGNATURE** - If Income Section is completed, the adult signing the form must also list the last four (4) digits of his or her Social Security number, or check the "I do not have a Social Security number" box below.

"I certify (promise) that all information on this application is true and that all income is reported. I understand the school will be eligible for certain federal and/or state funds based on the information I give. I understand that the school officials may verify (check) the information. I understand that if I purposely give false information, my child may lose benefits and I may be prosecuted."

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Last Four (4) Digits of Adult Social Security Number **XXX-XX-**\_\_\_\_\_  **I do not have a Social Security Number**

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone	Work Phone	Email Address
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By providing your email address, you may be contact via email by the district





\_\_\_\_\_ intends to enroll in CCA-Dana (IRN 012951; "Columbus Collegiate Academy-West"), and his/her projected first day of school is August 23, 2017.

**Please send the listed documents to:**

*Email:* admissions.ccadana@unitedschoolsnetwork.org

*Fax:* 614-375-1702

*Mail:* Columbus Collegiate Academy - Dana  
 Attn: Operations Staff  
 300 Dana Avenue  
 Columbus, OH 43223

*For questions regarding the student's enrollment or this request for permanent records, please call the main office at 614-545-9570.*

- 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 \_\_\_\_\_