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** |
|---|---|---|
| | | |

**HEALTH 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 6 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

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 - Main 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 12th 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 |
| **7. Total Monthly Household Income** (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 |
|---|---|---|
| | | By providing your email address, you may be contact via email by the district |

**OFFICE USE ONLY** - Circle only one QUALIFIES DOES NOT QUALIFY

UNITED SCHOOLS NETWORK
COLUMBUS COLLEGIATE ACADEMY
MAIN

# **RECORDS** REQUEST

2017-2018 SCHOOL YEAR

_____ intends to enroll in CCA-Main (IRN 009122; "Columbus Collegiate Academy"), 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 _____