

CIRCLEVILLE CITY SCHOOLS



CCS REGISTRATION PACKET 2019-2020

**CIRCLEVILLE CITY
SCHOOLS
NEW STUDENT ENROLLMENT
PROCEDURES**

Welcome to Circleville City Schools! To begin the student enrollment process, please contact the District Office at 740.474.4340 to set up an appointment. Your child will NOT need to be present for the registration. Kindergarten students must be five years old on or before August 1st. All new students must be registered by a custodial parent or legal guardian. Please bring the completed packet and all required documents to your scheduled appointment.

Documents needed for registration:

- Photo I.D. for parent or guardian
- Copy of Certified Birth Certificate for student
- Immunization Records
- Copy of Custody Orders, if parents are divorced and/or legally separated

Proof of Residency is required, verification of your address must be provided through TWO (2) acceptable forms of documentation. Examples of acceptable forms of documentation include but are not limited to the following:

- Official Rental/Lease Agreement
- Property Tax Statement
- Utility Bill (within 30 days)
 - o Only ONE (1) utility bill will be accepted for verification. You will need to provide us with another type of documentation for your second verification.
- Mortgage Coupon/ Closing Settlement Statement of purchase
- Ohio Driver's License or State issued I.D. with current address

- Special Circumstances may exist as applicant resides with another person. The person with whom you are living with **MUST COMPLETE THE RESIDENCE VERIFICATION AFFIDAVIT II** form and have it notarized. They **MUST ALSO PROVIDE PROOF OF RESIDENCY** to school officials through TWO (2) acceptable forms of documentation. Acceptable forms of documentation include but are not limited to the examples above.

ADDITIONAL REGISTRATION FORM FOR KINDERGARTEN ONLY:

- Speech, Hearing and Language Summary

ADDITIONAL REGISTRATION FORM FOR PRESCHOOL ONLY:

- Child Medical Statement (must be completed by Doctor)
- Confidential Dental Health Record (must be completed by Dentist)

REGISTRATION FORM FOR ALL STUDENTS

School Year: _____

Has your child ever been enrolled in Circleville City Schools? Yes ___ No___ If yes, what building? _____

Student's Legal Name: _____
First
Middle
Last

Preferred Name: _____ Social Security Number: _____ Gender: Male ___ Female ___

Date of Birth: _____ Grade _____ Place of Birth: _____
City
State
Country

Address: _____ County _____
Street #, Lot #, Apartment#, P.O. Box
City
Zip

Parent/Guardian Information:

Mother's Maiden Name: _____

Status of biological parents: Married ___ Divorced ___ Separated ___ Widowed ___ Never Married ___

Student resides with: Mother ___ Father ___ Guardian ___

If divorced, who has legal custody? Mother ___ Father ___ Shared ___ If shared, who is residential? _____

Are you the biological/adoptive parent (s) of the child? Yes ___ No ___ If no, what is your relationship to the child? _____

If foster/guardian, what district did the natural parent(s) reside in at the time you received custody? _____

(If other than Circleville, assignment of tuition is required)

Foster Agency: _____

Case Worker: _____ **Phone:** _____

Please Check One

Father ___ **Guardian** ___

Name: _____

Address:(if different from student) _____

Cell: _____

Other: _____

One Call Notice: Cell ___ Other ___

Place of Employment: _____

Work phone: _____

Step-Mother (if applicable): _____

Cell: _____ Work: _____

Please Check One

Mother ___ **Guardian** ___

Name: _____

Address:(if different from student) _____

Cell: _____

Other: _____

One Call Notice: Cell ___ Other ___

Place of Employment: _____

Work phone: _____

Step-Father (if applicable): _____

Cell: _____ Work: _____

Citizen Status of Student

U.S. Citizen Yes ___

U.S. Citizen No ___ Non-Resident ___ Permanent Resident Status ___ Exchange Student ___ Other _____

Racial/Ethnic Group

Is the student Hispanic or Latino? Yes ___ No ___

What is the student's race? **You must choose at least one.**

White/Non-Hispanic ___

American Indian or Alaskan Native ___

Asian ___ Multiracial ___

Black/Non-Hispanic ___

Native Hawaiian or Other Pacific Islander ___

Hispanic ___

Language

Native Language _____ Language spoken in the home _____

Special Services:Has your child been identified or received services for one of the following? **(Please check all that apply)**

Individual Educational Plan (IEP) ___

504 Individualized Accommodation Plan ___

English as Second Language (ESL) ___

Has your child ever been identified as gifted? Yes ___ No ___

Is this student currently expelled or under suspension from any other school district? Yes ___ No ___**Parent in Military:**

Is either parent currently serving in the Military? Yes ___ No ___ Is either parent a Military Veteran? Yes ___ No ___

If YES, Reserve ___ National Guard ___ Army ___ Navy ___ Air Force ___ Marines ___ Coast Guard ___

Where do you live?

Own ___

Rent ___

With someone (example: friend, parent, sibling) ___

Other _____

I attest as evidenced by my signature below that all of the above information is correct to the best of my knowledge:

Parent/Guardian Signature: _____ Date: _____

Parent/ Guardian E-Mail: _____

CIRCLEVILLE CITY SCHOOLS
Residence Verification Form – Affidavit I

I certify that I am a resident of the _____ *School District* at the following address:

Address: _____

City/Zip Code: _____

Date of Occupancy: _____

Verification of the above residence must be provided to school officials through two acceptable forms of documentation. Examples of acceptable forms of documentation include, but are not limited to the following:

- Official Rental/Lease Agreement
- Property Tax Statement
- Utility Bill (within 30 days)
 - Only ONE (1) utility bill will be accepted for verification. You will need to provide us with another type of documentation for your second verification.
- Mortgage Coupon/ Closing Settlement Statement of purchase
- Ohio Driver's License or State issued I.D. with current address

- Special Circumstances may exist if applicant resides with another person. The person with whom you are living with **MUST COMPLETE THE RESIDENCE VERIFICATION AFFIDAVIT II** form and have it notarized. They **MUST ALSO PROVIDE PROOF OF RESIDENCY** to school officials through **TWO (2)** acceptable forms of documentation. Acceptable forms of documentation include but are not limited to the examples above.

Please list other children enrolled with Circleville City Schools:

Student(s)	Date of Birth	Grade

I further certify that the above information is true and accurate. I understand that if residency at any time is verified to be false that immediate withdrawal can occur.

 Parent/Guardian Signature

 Relationship to Child

 Date

CIRCLEVILLE CITY SCHOOLS
Special Circumstances Verification Form Affidavit II

To be completed by the person(s) with which you reside

I, _____, being duly cautioned, do solemnly swear or affirm the following:

1. I am the owner or renter of the residence at

In _____, Ohio located in the _____

School District.

2. The following individual(s) is/are living at my above stated residence and have so since the ____ day of _____, 20____.

3. I acknowledge and understand that if the above information is not true and correct, that knowingly swearing of affirming the truth thereof constitutes criminal falsification, a violation of Ohio Revised Code Section 2921.13, a first degree misdemeanor, punishable by a maximum fine of \$1,000.00 and/or a maximum term of imprisonment of six months. Inaccurate and/or falsified information will result in immediate withdrawal of stated student(s) from Circleville City Schools.

4. Owner/renter of the above residence must provide two forms of proof of residency from the following list:

- Official Rental/Lease Agreement
- Property Tax Statement
- Utility Bill (within 30 days)
 - o Only ONE (1) utility bill will be accepted for verification. You will need to provide us with another type of documentation for your second verification.
- Mortgage Coupon/ Closing Settlement Statement of purchase
- Ohio Driver's License or State issued I.D. with current address

I agree that Circleville City Schools, if they deem necessary, has the right to investigate my residency. I agree to allow the release of ownership, rental, and utility information to a representative of Circleville City Schools.

Signature: _____
 (Property owner/Lessee)

Sworn to and ascribed in my presence this _____ day of _____, 20____

 Notary Public

Stamp or Seal

CIRCLEVILLE CITY SCHOOLS EMERGENCY MEDICAL AUTHORIZATION FORM

NOTIFY THE SCHOOL OF ANY CHANGE IN PHONE OR EMERGENCY NUMBERS

Student Name _____ School _____

Address _____ Telephone _____

The following is required by section 3313.712 of the Ohio Revised Code.

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. **Only individuals listed on this form will be permitted to pick up a child upon providing proof of identification.**

Residential Parent or Guardian:

Mother's Name _____ Daytime Phone _____

Father's Name _____ Daytime Phone _____

Other's Name _____ Daytime Phone _____

Name of Relative or Childcare Provider _____

Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

PART I OR II MUST BE COMPLETED

PART I – (TO GRANT CONSENT)

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____ Medical

Specialist _____ Phone _____ Local

Hospital _____ Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated preferred physician is not available, by another licensed physician or dentist; and (2) 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 such surgery.**

Date Signature of Parent/Guardian Address

PART II – (REFUSAL TO GRANT CONSENT)

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Date Signature of Parent/Guardian Address

SCHOOL: _____

STUDENT'S NAME: _____

PARENTS/GUARDIANS:

PLEASE COMPLETE CONFIDENTIAL INFORMATION TO BE SHARED WITH TEACHING STAFF AND EMS IF NECESSARY – If an emergency situation occurs, every effort will be made to transport your child to the hospital of choice. But, if necessary, protocol of EMS personnel is to transport to the nearest hospital.

1. Does your child have asthma **diagnosed by a physician?** Yes _____ No _____
If yes, please list any treatments given or medication taken _____

2. Does your child have allergies (reactions to medications, foods, or insects) **diagnosed by a physician?** Yes _____ No _____ If yes, please list the care or medication required _____

3. Does your child have ADHD **diagnosed by a physician?** Yes _____ No _____
If yes, and he/she takes medication, please list medication, amount, and time of administration _____

4. Does your child have a seizure disorder **diagnosed by a physician?** Yes _____ No _____
If yes, and he/she takes medication, please list medication, amount and time of administration _____

5. Does your child have a cardiac(heart) defect **diagnosed by a physician?** Yes _____ No _____
If yes, please list any restrictions and medications, amount, and time of administration _____

6. Does your child have a bleeding disorder/tendency **diagnosed by a physician?** Yes _____ No _____
If yes, please give diagnosis or description of problem _____

7. Does your child have diabetes **diagnosed by a physician?** Yes _____ No _____ Type _____

If Type 1, please list insulin pen/insulin pump and time glucose is checked or insulin is given _____

8. Does your child have vision/hearing impairment? Yes _____ No _____
Wear glasses, contact lenses, or hearing aid(s)/auditory device? _____

9. Any other pertinent medical information or medications being given that could affect your child while in school _____

AUTHORIZATION TO DISCLOSE IMMUNIZATION INFORMATION

Name of Child _____ Date of Birth _____

I, _____, as the **parent or guardian** of the above named child, hereby authorize
(name of doctor(s)) _____

to disclose the specific and individually identifiable immunization records of the above named child to Circleville City Schools for the specific purpose of presenting written evidence, satisfactory to the person in charge of admission, that the above named child has been immunized by a method of immunization approved by the Department of Health as required by section 3313.671 of the Ohio Revised Code.

This authorization will expire upon the presentation of written evidence sufficient to comply with section 3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the *Revocation Section*. I further understand that any action taken by the above named Provider(s) or School in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law. **Please note: medical records provided to schools that receive federal funding are protected by the Family Education Rights and Privacy Act (FERPA).**

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I also understand that my refusal to sign this authorization may prevent the school from verifying that the above named child has been immunized. I further understand that if the school cannot verify and I cannot provide satisfactory written evidence that the above named child has been immunized the child may be excluded from school pursuant to section 3313.671 of the Ohio Revised Code.

I further understand that I may request a copy of this signed authorization.

(Signature of Personal Representative)

(Date)

(Relationship/ Authority)

Note: *This Authorization was revoked on:* _____

(Date)

(Signature of Staff)

AUTHORIZATION TO DISCLOSE IMMUNIZATION INFORMATION

Fill out this section if you do not want the school to contact your health care provider.

REVOCAION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Child/Patient)

signed by _____ on _____
(Name of person who signed authorization) (Date of Signature)

be rescinded, effective _____.
(Date)

I understand that any action taken by the named Provider(s) or School in accordance to this authorization prior to the revocation date is legal and binding.

(Signature of Client/Patient)

(Date)

(Signature of Witness)

(Date)

(Signature of Personal Representative)

(Date)

(Relationship/ Authority)

CIRCLEVILLE CITY SCHOOLS

Circleville, Ohio 43113

Parent Authorization for Release of Confidential Information

Student's Name		Grade		Date of Birth	
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I hereby request and authorize that confidential information concerning my child be released to:

Student Services Department 100 Tiger Drive Circleville, Ohio 43113 740.477.6663 Fax: 740.477.6681	Circleville District Office 388 Clark Drive Circleville, Ohio 43113 740.474.4340 Fax: 740.474.6600	Circleville Elementary 100 Tiger Drive Circleville, Ohio 43113 740.474.2495 Fax: 740.477.6681	Circleville Middle School 360 Clark Drive Circleville, Ohio 43113 740.474.2345 Fax: 740.477.6684	Circleville High School Guidance Department 380 Clark Drive Circleville, Ohio 43113 740.477.5553 Fax: 740.477.5571
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Date Mailed: _____

Date Faxed: _____

START Date: _____

DISTRICT IRN # 043760**Records to be released should include those that apply to student:**Attendance/ Academic Records (Assessment Data, Grading Scale, etc.) Special Education Documents
(ETR/MFE, IEP, Reports, Diagnostics, etc.) General Education Documents (504 Plans) ESL, Gifted Education, SSID**COMPLETE THE FOLLOWING INFORMATION ABOUT THE LAST SCHOOL ATTENDED:**

Has your child been identified or received services for one of the following? Please check below.

<input type="checkbox"/>	Special Education and Related Services (IEP, ETR)	<input type="checkbox"/>	504 Plan(Accommodation in General Ed. Setting)
<input type="checkbox"/>	ESL (English as Second Language)	<input type="checkbox"/>	Gifted Education (WEP or WAP)
<input type="checkbox"/>	NONE OF THE ABOVE	<input type="checkbox"/>	

School Name				
School Address				
City		State		Zip
School Phone		School Fax		

LAST DATE OF ATTENDANCE: _____

Reason for Request:

<input type="checkbox"/>	Child has moved into Circleville City School District
<input type="checkbox"/>	My child has been accepted at Circleville City Schools under Open Enrollment
<input type="checkbox"/>	Child is COURT PLACED in Circleville City School District

Parent/Guardian Name PRINTED: _____

Parent/ Guardian Signature: _____

Parent/ Guardian Current Address: _____

Kindergarten ONLY

SPEECH, HEARING AND LANGUAGE SUMMARY KINDERGARTEN SCREENING For Kindergarten Registration Only

Child's Name: _____

Please check those statements, which apply to your child:

- I am worried about my child's speech or language skills.
- My child has a history of hearing problems (tubes, frequent earaches).
- My child has difficulty following directions or answering questions.
- My child has difficulty using complete sentences. Example: Me going school.
- My child has difficulty pronouncing certain sounds: Example: poon for spoon or tat for cat.
- My child has had speech therapy at:
 - ◇ Head Start
 - ◇ Summer Clinic
 - ◇ Other _____
- I am interested in talking with a speech therapist about my child's speech.
- Any other information the speech therapist may need to know:

Preschool ONLY



Department
of Education

Office of Early Learning and School Readiness
Child Medical Statement

Revised 3/12/2018

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Child Medical Information

Child's Name

Date of Birth Height Weight

Immunizations:	Exempt from Immunization:
Complete for Age <input type="radio"/> Yes <input type="radio"/> No	Religious Conviction <input type="radio"/> Yes <input type="radio"/> No
In Process <input type="radio"/> Yes <input type="radio"/> No	Health <input type="radio"/> Yes <input type="radio"/> No
	Other <input type="text"/>

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name Provider Address

Provider Phone Number Provider City Provider State Provider Zip

Check box of examining medical professional:

- Physician
 Physician Assistant
 Advanced Practice Registered Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional Date of Exam

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

Preschool ONLY

Confidential Dental Health Record

Child's Name _____ Sex: M F Birthdate: _____ Address: _____
 Dentist: _____ Phone _____

PART A: To be completed by Parent/Guardian: If "yes", include length of time

1. Is the child now receiving fluoride? No _____ Unknown _____ Yes _____
 Topical Fluoride Application? No _____ Unknown _____ Yes _____
 Fluoridated water? No _____ Unknown _____ Yes _____
 Fluoride supplement diet? (tablets, liquid) No _____ Unknown _____ Yes _____

2. Does the child have any trouble with teeth, gums, or mouth that the parent knows about?
 No _____ Yes _____

3. Child (_____) has (_____) previously seen a dentist
 Dentist name: _____ Date of last visit: _____

4. Child (_____) is (not) under a physician's care
 Physician's name: _____ Date of last visit: _____

5. Child (_____) is (not) receiving medication
 Type _____

6. Child is reported to have:
 Allergies _____ Liver Disease _____
 Asthma _____ Rheumatic Fever _____
 Bleeding _____ Sickle cell disorder _____
 Diabetes _____ Heart/Vas. Disorder _____
 Epilepsy _____ Other _____

PART B: Parental Consent:
 I have been informed of my child's dental health plan and agree to the recommended treatment.
 Parent signature: _____ Date: _____

PART C: To be completed by dental care provider:

1. Oral conditions before treatment:
 Missing: ☒
 Decayed: ●
 Filled: ○
 Indicate restorations you perform in item 2.

2. Examination and Treatment Record:					
Tooth ID	Surfaces	Description of work	Date Performed	A.D.A.#	Fee

3. Dental needs:
 Treatment _____ Fluoride _____ Approx # of visits _____
 (restoration, extraction, Pulp therapy) _____ Cleaning _____ Approx cost _____
 No problems _____ Other _____

4. Child Oral Health Summary
 All planned treatment (_____ is not) complete. If not, explain here: _____

Routine recall visits _____ Developmental problems _____
 Dietary problems _____ Special home emphasis, oral hygiene _____
 Needs fluoride supplement _____ Harmful oral habits _____
 Dentist signature _____ Date _____