



UNITED SCHOOLS NETWORK

UNITE TODAY. CHANGE TOMORROW.

Enrollment Form: 2017 – 2018 School Year

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)

EXCELLENCE
CULTURE
COMMITMENT
PASSION
INTEGRITY

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: _____

UNITED SCHOOLS NETWORK | 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

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 #

() -

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
<input type="checkbox"/> Glasses	<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Sleeping
<input type="checkbox"/> Contacts	<input type="checkbox"/> Hearing aid (left or right)	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Skin Rashes/Lesions
<input type="checkbox"/> Amblyopia	<input type="checkbox"/> Tubes	<input type="checkbox"/> Bi-Polar	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Estropia		<input type="checkbox"/> OCD	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Frequent Infections		<input type="checkbox"/> ODD	<input type="checkbox"/> Requires Diapers
		<input type="checkbox"/> Bladder	<input type="checkbox"/> Bowel
		<input type="checkbox"/> Special Diet	<input type="checkbox"/> Breathing
		<input type="checkbox"/> Dental	<input type="checkbox"/> Menstruation
		<input type="checkbox"/> Neurological	<input type="checkbox"/> Nosebleeds
		<input type="checkbox"/> Phobias	<input type="checkbox"/> 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

_____ intends to enroll in UPrep-Main, and the student's projected first day will be August 23, 2017.

Please send the following information to:

United Preparatory Academy - Main
Attn: Operations Staff
1469 East Main Street
Columbus, Ohio 43205
Ph: 614.557.3574
Fax: 614.299.5303

Cumulative Records
Physician's Record
Dental Record
Expulsion/Suspension Documents

Special Education (IEP/ETR/504)
Grade Card
Birth Certificate

Copy of Student's Data Form
Immunization Record
Ohio State Test Results

Name of School Child Last Attended		
School District		
School Address		
City, Zip Code		
Last Grade Attended	PreK	K

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,
Office Manager
UPrep-Main