# CIRCLEVILLE CITY SCHOOLS

# CCS REGISTRATION PACKET
# 2019-2020

Revised 2/2019

# 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)
    - 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 _____

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**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 __

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**Is this student currently expelled or under suspension from any other school district? Yes __ No __**

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**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 _____

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*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**

Tobe 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)
     - 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

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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** ADD or 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.*

## REVOCATION 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 | |
|---|---|---|---|---|---|

**I hereby request and authorize that confidential information concerning my child be released to:**

| ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|
| **Student Services Department**<br>100 Tiger Drive<br>Circleville, Ohio 43113<br>740.477.6663<br>Fax: 740.477.6681 | **Circleville District Office**<br>388 Clark Drive<br>Circleville, Ohio 43113<br>740.474.4340<br>Fax: 740.474.6600 | **Circleville Elementary**<br>100 Tiger Drive<br>Circleville, Ohio 43113<br>740.474.2495<br>Fax: 740.477.6681 | **Circleville Middle School**<br>360 Clark Drive<br>Circleville, Ohio 43113<br>740.474.2345<br>Fax: 740.477.6684 | **Circleville High School**<br>Guidance Department<br>380 Clark Drive<br>Circleville, Ohio 43113<br>740.477.5553<br>Fax: 740.477.5571 |

**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.**

| | | | |
|---|---|---|---|
| | **Special Education and Related Services (IEP, ETR)** | | **504 Plan(Accommodation in General Ed. Setting)** |
| | **ESL (English as Second Language)** | | **Gifted Education (WEP or WAP)** |
| | **NONE OF THE ABOVE** | | |

| | | | | | |
|---|---|---|---|---|---|
| **School Name** | | | | | |
| **School Address** | | | | | |
| **City** | | **State** | | **Zip** | |
| **School Phone** | | | **School Fax** | | |

**LAST DATE OF ATTENDANCE:** _____

Reason for Request:

| | |
|---|---|
| | **Child has moved into Circleville City School District** |
| | **My child has been accepted at Circleville City Schools under Open Enrollment** |
| | **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

Ohio | 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 | ◯ Yes ◯ No | Religious Conviction | ◯ Yes ◯ No |
| In Process | ◯ Yes ◯ No | Health | ◯ Yes ◯ No |
| | | Other | |

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.

# Confidential Dental Health Record

Child's Name _____ Sex: M F Birthdate: _____

Dentist: _____ Address: _____ Phone _____

**PART A:** To be completed by Parent/Guardian:

1. Is the child now receiving fluoride? If "yes", include length of time

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 _____has not) previously seen a dentist
   Dentist name: _____ Date of last visit: _____

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

5. Child (_____is_____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 | Treatment Approved | 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____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 _____