RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT

REGISTRATION PACKET

"It's a New Day for the Richmond Heights Way"

447 Richmond Road, Richmond Heights Ohio 44143
(216) 692-0086

www.richmondheightsschools.org

RICHMOND HEIGHTS LOCAL SCHOOLS

447 RICHMOND RD. RICHMOND HTS., OHIO 44143 PHONE: 216-692-0086 FAX: 216-692-8487

"It's the Dawning of a New Day"

Welcome New Families and Partners in Education

We are so excited to welcome you to Spartan Nation and want to ensure that your child has a smooth transition to Richmond Heights Local Schools.

In order to meet that goal we will need ALL documents noted on the enrollment package. Therefore we strongly recommend you come prepared with all information to support a complete enrollment and a smooth transition. Upon a completed enrollment package, your child/children will begin school in 48 hours. This process is to allow the guidance counselor opportunity to schedule accordingly and the review of any documents that indicate exceptionalism and proper placement. Some pertinent documents that support a smooth transition that can be obtained from the previous school district are: transcripts, 504, IEP's and ETR's.

If you are unable to provide ALL documents at the time of enrollment, your child/children cannot begin school at Richmond Heights Local Schools until the registrar's office is in receipt of a complete enrollment package. Please refer to the enrollment package for the required documents.

If you have any questions of clarification, please feel free to contact me at askew.kelly@richmondheightsschools.org.

Thank you and Welcome to Spartan Nation,

Kelly Askew-Tucker

Kelly Askew-Tucker
Director of Educational Services
216-692-0086 ext.571228

RICHMOND HEIGHTS LOCAL SCHOOLS

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REGISTRATION PACKET CHECK LIST

Parents, legal custodians or guardians must register their children **by appointment only** at the Board of Education Office. To schedule an appointment, please call **Ms. Bendes** at **(216) 692-7395**. Use the checklist below for the registration process to move quickly. Please supply the district with the following documents:

1. ____ A current **Driver's License** or current **State ID** of the adult registering the student.
2. ____ Completed registration forms (attached).
3. ____ **Original or certified** copy of child's **Birth Certificate**.
4. ____ Child's **Social Security Card** of proof of number.
5. ____ Stamped, certified copy of **court order** establishing custody or guardianship (if applicable).
6. ____ **Notarized Residency Affidavit.**
7. ____ **Current Lease, Mortgage Statement, Deed or Tax Bill**
8. ____ Child's complete **Immunization records** signed by your physician or from previous school.
9. ____ **Records** from previous school such as, **Transcripts** or last grade report, **IEP and ETR.**
10. ____ **Withdrawal Form** from previous school.

As the parent or legal guardian of the children being registered, you have a continuing responsibility to inform the superintendent of schools of any change of residence or legal custody. Regarding legal custody or guardianship, a court of jurisdiction must award it before a student will be allowed to enroll in the Richmond Heights Local School District.

The Richmond Heights Schools attendance officer will confirm the accuracy of information provided during the registration process by making home visits to all new students.

I have read the above enrollment procedures, understand them and will abide by them. I will notify the superintendent of schools of any changes that may occur.

Signature_____ Date_____

RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT

RESIDENCY AND CUSTODY AFFIDAVIT

For the purpose of establishing school residence and custody (To be completed by parent or legal guardian)

SIGN ONLY AFTER CAREFULLY READING AND SIGNING IN THE PRESENCE OF A NOTARY

THE UNDERSIGNED, FIRST BEING DULY SWORN ACCORDING TO LAW, STATE THAT:

I,_____, certify that I am the custodial parent/legal guardian of _____
(Parent's or Legal Guardian's Full Name) (Student's Name)

and that I have established residency at _____
(Street Number, Name, Apt. #) (City) (State) (Zip Code)

Date of Occupancy:_____ Lease End Date (if applicable): _____

I, _____, certify that I am a resident of the above residence located within **Richmond Heights Local School District**. The registrar has explained to me that legal residency is determined by certain conditions, among them are that mail delivery, voting residence, and payroll city tax deductions are based on the ***Richmond Heights Local School District*** address and also, that the residence where meals are taken, and where the resident parent sleeps must be the ***Richmond Heights Local School District/Richmond Heights*** residence. (Photo identification, such as an Ohio Driver's License with your most recent address, is required for identification)

List the names of **ALL** people, both adults and children, who reside at the above address. Also, please indicate their school (if applicable) and "status" (i.e., homeowner, lessee, renter, parent, guardian, student, preschooler, grandparent, etc.) Attach a separate piece of paper, if needed.

Last Name	First Name	School (If Applicable)	Last Name	First Name	School (If Applicable)

Please read each statement and then place your initials to the left of the statement.

_____ I/we certify **that the information provided in this document and registration packet is true** and no information has been withheld, concealed, or misrepresented for the purpose of circumventing the school attendance laws of the State of Ohio in order to enroll named students in the ***Richmond Heights Local School District.***

_____ I/we understand that I/we are responsible for informing school officials of any change(s) in the residence of any parent, legal guardian, or other responsible adult. If I change my present address to another address that is within the **Richmond Heights Local School District**, I will **immediately** file another residency and custody affidavit with the Board of Education of the **Richmond Heights Local School District.** I further understand that if the above noted address ceases to be my legal residence and my new residence is outside the boundaries of the **Richmond Heights Local School District**, I will withdraw my child(ren) from the district and will enroll my child(ren) in the new district of residence.

_____ I/we are also responsible for informing school officials of any changes to the legal custody or guardianship of the child(ren).

_____ I/we have provided the **Richmond Heights Local School District** with an official copy of any and all current court orders from the Domestic Relations, Juvenile, Probate or any other court which has exercised jurisdiction over the custody or residency of the children being enrolled as per Ohio Revised Code 3313.672.

_____ I/we acknowledge the student who is being registered has not been expelled or excluded from any other school pursuant to O.R.C. Sections 3301.121 and 3313.662.

_____ I/we understand that if the student attends school while not being eligible to do so tuition free, the student and all responsible parties will be liable for tuition at a rate set by the Ohio Department of Education according to the Ohio Revised Code 3317.08 , and related costs, and the student will immediately be withdrawn from the **Richmond Heights Local School District.**

_____ I/we understand that the **Richmond Heights Local School District** may use whatever legal means it has at its disposal to verify my residency. I/we hereby waive my rights to confidentiality of information relative to my/our residence and give permission to the **Richmond Heights Local School District**, the City Tax Administrator, and the Regional Income Tax Agency (RITA) to release information such as name, social security number, and current and former addresses to confirm or deny my residency for the current or prior years.

NOTE: Be sure you have read this statement carefully before you sign. **Giving false information under oath is punishable as a criminal offense** under the Ohio Revised Code 2921.13 and 2921.21, a misdemeanor of the first degree with a maximum fine of $1,000 and/or a jail term of six months. In cooperation with the City Prosecutors, each violation may be thoroughly and vigorously prosecuted.

Signature(s)

Parent/Legal Guardian/Custodian: _____

Student 18 years of age or older: _____

County of Cuyahoga)

)SS

State of Ohio)

Before me, a Notary Public of the State of Ohio, came the above-named who said that he/she/they did understand the statements set forth above and did adopt said statements and the information, herein as his/her/their own, as true to the best of his/her knowledge of the consequences and penalties of falsification, and did affix his/her signature in my presence,

This _____ day of _____, 20____

_____
Notary Public

RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT

STUDENT REGISTRATION FORM

Student Name	Last Name	First Name	Middle Name	Entry Grade
Social Security # (optional)	- -	**Birth Date**	Month /	Day / Year
Student Home Address	Number Street	City	Zip Code	Up ☐ Down ☐ Apt. #
Parent/Guardian	Name		Phone Number	
Previous school attended Include homeschooling	Name of School	School District	City	State

Is this student Hispanic/Latino?

☐ No, not Hispanic/Latino

☐ Yes, Hispanic/Latino

Race (choose one or more)

☐ White
☐ Black or African American
☐ Asian
☐ American Indian or Alaskan Native
☐ Native Hawaiian or Other Pacific Islander

How Identified:

Gender ☐ Male ☐ Female

Citizenship

☐ Dual National
☐ Non-Resident Alien
☐ Resident Alien
☐ U.S. Citizen
☐ Other please name:

Birthplace City State Country

Native / Primary Language

☐ English
☐ Other please name:

Student Lives With (check all that apply)

☐ Mother
☐ Father
☐ Step-Parent
☐ Other (explain):
☐ Guardian
☐ Spouse
☐ Self

Legal Custody (check all that apply)

☐ Mother
☐ Father
☐ Foster Parent
☐ Guardian
☐ CCDCFS
☐ Other (explain):

Court Journal Entry: (____/____/____) ☐ Probate Court ☐ Juvenile Court

County: _____ Restrictions: _____

District Bearing Cost(for Foster Children only):

Is the child in gifted or Advanced Placement?	Yes ☐	No ☐	If yes, describe services:
Does the child have a 504 plan?	Yes ☐	No ☐	If yes, describe services:
Has the child ever had an IEP?	Yes ☐	No ☐	If yes, list year of most recent evaluation:
If yes, do you have a copy of the IEP?	Yes ☐	No ☐	If yes, indicate program:
Is the child suspended?	Yes ☐	No ☐	If yes, from what district?
Is the child expelled?	Yes ☐	No ☐	If yes, from what district? End Date:

☐ I do not consent to the release of email, home address, and home phone number for outreach purposes

Daycare/Preschool/Kindergarten Questionnaire

Has your child been in a previous school setting: ☐ Yes ☐ No

If so, please name school(s): _____ Address _____

City _____ State _____ Phone Number _____

Permission to Contact: ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____

PARENT(S) / GUARDIAN INFORMATION

STUDENT NAME:

Mother ☐Single ☐Married ☐Divorced ☐Separated ☐Remarried ☐Deceased

Dual Mailing: ☐Residential ☐Non-Residential ☐Yes ☐No

Last Name | First Name

Address: Number Street City Zip Code

Workplace | Email

Home Phone | Work Phone | Cellular Phone

Father ☐Single ☐Married ☐Divorced ☐Separated ☐Remarried ☐Deceased

Dual Mailing: ☐Residential ☐Non-Residential ☐Yes ☐No

Last Name | First Name

Address: Number Street City Zip Code

Workplace | Email

Home Phone | Work Phone | Cellular Phone

☐ **Legal Guardian** ☐ **Step Parent** ☐ **Foster Parent** ☐ **Other:**

Last Name | First Name

Address: Number Street City Zip Code

Workplace | Email

Home Phone | Work Phone | Cellular Phone

Social Worker (*If Applicable*):

☐ **Legal Guardian** ☐ **Step Parent** ☐ **Foster Parent** ☐ **Other:**

Last Name | First Name

Address: Number Street City Zip Code

Workplace | Email

Home Phone | Work Phone | Cellular Phone

Social Worker (*If Applicable*):

EMERGENCY CONTACT INFORMATION

Name / Relationship	Name / Relationship
Telephone	Telephone
Address	Address
Email	Email

PLEASE LIST ALL OTHER CHILDREN UNDER THE AGE OF 22 WHO LIVE AT THE HOME ADDRESS

Name	Grade	Date of Birth	Gender	Relationship To Student

I hereby certify, under penalty of perjury, that all of the information that I have given is correct in all respects to the best of my knowledge.

Date:_____ Parent/Legal Guardian/Independent Student: _____

Signature

Date: | Information Verified By:

RICHMOND HEIGHTS LOCAL SCHOOLS

REQUEST FOR TRANSFER OF STUDENT RECORDS

RECORDS OF: _____ _____ _____
Student *Grade* *Date of Birth*

_____ _____
Former Address *City, State, Zip, Country*

RELEASED FROM: _____
School/Agency

_____
Address

_____
City, State, Zip

Phone_____Fax_____

RELEASE TO: **Richmond Heights Board of Education**
Registrar
447 Richmond Road
Richmond Heights, OH 44143
Phone: 216/692-7395
Fax: 216/692-8487
Email: bendes.kathy@richmondheightsschools.org
1st Day of Admission_____

Please include any or all listed below:

____ Transcripts/Academic Grades
____ Grades to Date of Withdrawal
____ Standardized Test Scores
____ Individual Career Plan
____ Health and Immunization Records
____ IEP/ETR
____ 504 Plan
____Other, please specify _____

I acknowledge notification of this transfer of records as required by the Family Educational Rights and Privacy Act of 1974 and I understand that I have the right to receive a copy, if requested, and have an opportunity for a hearing to challenge the content of the records. I understand that the information transferred will be treated in a confidential manner and will not be transmitted to a third party without my consent.

_____ _____ _____
Signature *Relationship* *Date*

Richmond Heights Local Schools

Emergency Medical Authorization

To enable parents and guardians to provide necessary information and to authorize the provision of emergency treatment for a student who becomes ill or is injured while under school authority.

Student Name _____ _____
Last First Middle Birth Date

Home Address _____ Apt. _____

Primary Phone (____) _____ E-mail _____

Parent(s) or Guardian with whom student lives:

_____ / _____
Name / Relation to student Name / Relation to student

Cell Phone (____) _____ **Cell Phone** (____) _____

Daytime (____) _____ **Daytime** (____) _____

Non-Residential Parent (If Applicable)

_____ (____) _____
Name / Relationship to Student Primary Phone

_____ _____ _____ _____ _____
Address Apt. City State Zip Code

Is there a court order which limits / prohibits non-custodial parent contact? O **Yes** O **No**
If yes is marked, parent must contact the office and provide legal documentation.

Transportation

Check all that applies: Bus to school ____ Bus from school ____ Car rider ____ Walk ____

* If your child does not go home after school, please list where the child goes, on what days, and phone number:

_____ (____) _____ M T W TH F
Name / Agency Phone Number **Circle Days**

Note: Requests to change normal transportation MUST be made in writing.

List the person(s) who will care for your child in the event that reasonable attempts to contact parent(s) have been unsuccessful. List contacts in the order in which you prefer them to be called.

1. _____ (____) _____
Name / Relationship to Student Primary Phone
2. _____ (____) _____
Name / Relationship to Student Primary Phone
3. _____ (____) _____
Name / Relationship to Student Primary Phone

Please include name of an older sibling who is authorized to pick up student in the event of a disaster.

_____ Grade _____

Information Concerning Student's Health – Please print

Medical History: _____

_____

Allergies (insect, food, medications, etc.): _____

_____

Physical impairments that limit mobility: _____

_____

Medications taken (including dosage and times given): _____

_____

****Please note: If your child would need to take any medication during a 24-hour period of "sheltering in place", please contact the school nurse to discuss this matter confidentially.**

Describe any **critical medical information** the bus driver should be aware of when transporting this student:

_____

_____

To Grant Consent

O **I grant consent,** in the event that reasonable attempts to contact me have been unsuccessful, (1) for the administration of any treatment deemed necessary by the named doctors:

Dr. _____ Phone Number (_____) _____
Preferred Physician

Dr. _____ Phone Number (_____) _____
Preferred Dentist

or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.

(2) the transfer of the child to (preferred hospital) _____, or 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 for such surgery, are obtained prior to the performance of such surgery.

_____ _____
Signature of Parent / Guardian Date

Refusal to Grant Consent

O **I refuse to grant consent** for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the school authorities to take the following action:

_____

_____

_____ _____
Signature of Parent / Guardian Date

I understand that I am responsible for keeping ALL information current and correct.

Ohio | Department of Education

Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

Student Name: *(First Name and Last Name)*	**Student Date of Birth:** *(mm/dd/yyyy)*

Communication Preferences Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.	1. In what language(s) would your family prefer to communicate with the school? _____
Language Background Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.	2. What language did your child learn first? _____ 3. What language does your child use the most at home? _____ 4. What languages are used in your home? _____
Prior Education Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.	5. In what country was your child born? _____ 6. Has your child ever received formal education outside of the United States? ☐ Yes ☐ No If yes, how many years/months? _____ If yes, what was the language of instruction? _____ 7. Has your child attended school in the United States? ☐ Yes ☐ No If yes, when did your child first attend a school in the United States? _____ / _____ / _____ Month Day Year
Additional Information Please share additional information to help us understand your child's language experiences and educational background.	

Parent/Guardian First Name: _____ Parent/Guardian Last Name: _____

Parent/Guardian Signature: _____ Today's Date: *(mm/dd/yyyy)* _____

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: https://www2.ed.gov/about/offices/list/ocr/ellresources.html

Ohio Department of Health • School and Adolescent Health

Immunization Report

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).
A copy of the child's immunization record may be attached or dates may be entered below.
Please note the month, day, and year for each immunization should be on record.

Vaccine	**Record complete dates** (month, day, year) **of vaccine doses given**					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____

Signature	Print name	Date
		/ /

HEA 4241 8/06

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone

Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail

Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL

Tuberculin Test

Date_____ **Type** _____ **Results**_____

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP