

RICHMOND HEIGHTS LOCAL SCHOOLS

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

REGISTRATION FORMS AND INFORMATION

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

1. A current **Drivers 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** or Passport.
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 Statement of Residence** submitted with appropriate documents (**lease, mortgage, or deed**). **The district will not enroll without proof of residence.**
7. Child's complete **Immunization records** signed by your physician or from previous school.
8. **No students will be enrolled without records from their previous school which include withdrawal slip, current grades, Immunizations, any current special education documentation and high school transcripts.**

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.

The Board shall not enroll a child free of any tuition obligation on a 60-day affidavit as set forth in ORC 3313.64 (E). Residents attempting to enroll students must provide evidence of legal custody.

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 SCHOOLS

MUST BE NOTORIZED TO BE REGISTERED

Statement of Residence

To the Richmond Heights Local School District Board of Education:

I, _____, certify that I am a full-time resident of the Richmond Heights Local School District and do not maintain a separate residence elsewhere. I live at:

Street Number and Name

Apartment #

Date of Occupancy

Telephone #

I further certify that this above information is true and accurate. I understand that if any of the provided information is false, I am liable for any penalties that the law provides under the criminal code and that I agree to pay the current tuition costs for each student listed below while illegally attending the Richmond Heights Local School District and further understand that immediate withdrawal of my children will occur.

List below the names of all children living with you at the above address:

Children

Birthdate

Children	Birthdate
_____	_____
_____	_____
_____	_____
_____	_____

Your relationship to student(s)

Note: Sign only in the presence of a notary public.

Signature _____ Date _____

The undersigned having been duly sworn says that all statements contained in the foregoing are true.

Subscribed and sworn to before me this _____ day of _____, 20____

Notary Public

REGISTRATION FORM

RICHMOND HEIGHTS LOCAL SCHOOLS

Information supplied on this form is required under provisions of Ohio law and Ohio Department of Education regulations

STUDENT DATA

Legal Name _____ Birth date: ____/____/____ Grade _____
Last First Middle Mo Day Yr
Male ___ Female ___ Age _____
Street Address _____ Apt.# _____ Social Security No. _____
City _____ State _____ Zip _____ Mothers Maiden Name _____
Telephone _____ Cell _____ Student's Birth City _____

Is the student Hispanic/Latino? ___ Yes ___ No

Is the student from ONE or MORE of the following five racial groups? (Considered Multiracial if more than one is checked)

Race/Ethnic Category ___ Black or African American ___ White
___ Asian ___ American Indian or Alaskan Native
___ Native Hawaiian or Other Pacific Islander

Primary Language Spoken at Home is: _____ E-mail _____

PREVIOUS SCHOOL DISTRICT INFORMATION

Name of Previous School _____
Address _____
City _____ State _____
Telephone _____

Student was in the following special programs:

___ I.E.P./Current IEP and MFE must be provided
___ 504
___ Gifted
___ Other _____

STUDENT LIVES

WITH (check one) ___ Mother & Father ___ Father/Stepmother ___ Other _____
___ Mother ONLY ___ Grandparent(s) (specify)
___ Father ONLY ___ Ward of Court
___ Mother/Stepfather

PARENTS ARE: ___ Married ___ Divorced ___ Separated ___ Never married ___ Other _____

COURT ORDERED PLACEMENT

No child will be admitted until current proof of legal custody is received (if applicable)

LEGAL CUSTODY ARRANGEMENTS:
___ Joint Custody
___ Mother ONLY
___ Father ONLY
___ Guardian
___ Foster Parent

CITIZEN STATUS: ___ U.S. Citizen ___ Resident Alien ___ Dual National ___ Non-Resident Alien

PARENT DATA

1. Natural Mother Name _____ Address _____
Employment _____ Work Phone _____

2. Natural Father Name _____ Address _____
Employment _____ Work Phone _____

Parent/Guardian Name _____ Address _____
(If student does not live with Natural Parent)
Employment _____ Work Phone _____

Parent/Guardian Name _____ Address _____
(If student does not live with Natural Parent)
Employment _____ Work Phone _____

Sibling information

NAME	AGE	GENDER	SCHOOL (If in school)
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1. Has your child ever been retained? _____ At what grade level? _____

2. Has your child been suspended? _____ When? _____ Where? _____

3. Is the student now under expulsion or scheduled for a hearing for expulsion in any school in Ohio? _____

4. When? _____ Where? _____ End Date _____

5. Is student currently under probation? _____ If so, name and phone number of probation officer _____

6. EMERGENCY INFORMATION. CONTACT OTHER THAN PARENT/GUARDIAN:

NAME _____ RELATIONSHIP _____ PHONE _____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE ABOVE INFORMATION IS TRUE. I CERTIFY THAT THE STUDENT'S NAME LISTED ON THE FIRST PAGE IS HIS/HER LEGAL NAME THAT I/WE HAVE LEGAL CUSTODY AND I/WE RESIDE WITHIN THE RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT BOUNDARIES. I UNDERSTAND THE RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT MAY USE LEGAL MEANS TO VERIFY MY RESIDENCE.

(Parent/Guardian Signature)

(Date)

Immunization Summary for Child Care, Head Start, Pre-School and School Attendance

VACCINES	<i>FALL 2011</i> IMMUNIZATIONS FOR CHILD CARE/HEAD START AND PRE-SCHOOL ATTENDANCE	<i>FALL 2011</i> IMMUNIZATIONS FOR SCHOOL ATTENDANCE
DTaP/DTP/DT Tdap/Td Diphtheria, Tetanus, Pertussis	4 doses of DTaP, DTP, or DT or any combination.	Kindergarten 5 doses of DTaP, DTP, or DT, or any combination, if the fourth dose was administered prior to the 4 th birthday Grades 1-12 3-4 doses of DTaP, DTP, DT or Td or any combination. Grades 7-8 1 dose of Tdap or Td vaccine must be administered prior to entry.
POLIO	3 doses of OPV or IPV or any combination of OPV or IPV.	K-1 3 or 4 doses of IPV, the final dose must be administered on or after the 4 th birthday regardless of the number of previous doses; 4 doses if a combination of OPV and IPV was administered. Grades 2-12 4 doses if a combination of OPV and IPV was administered. 4 doses of all OPV or all IPV is required if the third dose of either vaccine was administered prior to the 4 th birthday.
MMR Measles, Mumps, Rubella	1 dose of MMR administered on or after the first birthday	K-12 2 doses of MMR. Dose 1 must be administered on or after the first birthday. The second dose must be administered at least 28 days after dose 1.
Hib <i>Haemophilus Influenzae</i> Type b	3 or 4 doses depending on the vaccine type, the age when the child began the 1 st dose and the last dose must be after 12 months or 1 dose if given on or after 15 months of age	None
HEP B Hepatitis B	3 doses of Hepatitis B	K-12 3 doses of Hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the series (third or fourth dose), must not be administered before age 24 weeks.
Varicella (Chickenpox)	None	K-1 2 doses of varicella vaccine must be administered prior to entry. Grade 2-5 1 dose of varicella vaccine must be administered on or after the first birthday

NOTES:

- The 4 day "grace" period applies to all age and interval minimums. If MMR and Varicella are not given on the same day, the doses must be separated by at least 28 days with no grace period.
- The Tdap and Varicella requirements will be progressive.
- Only full doses of vaccine using proper intervals shall be counted as valid doses.
- For additional information please refer to the Ohio Administrative Code 5101:2-12-37 for Child Attendance. These documents list required and recommended immunizations and indicate exemptions to immunizations.
- Please contact the Ohio Department of Health Immunization Program at (800) 282-0546 or (614) 466-4643 with questions or concerns.

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Height	Weight	BMI percentile	BP

Screening Tests

Vision	Hearing	Postural
Date performed / /	Date performed / /	Date performed / /
Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical education classes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact and collision sports	<input type="checkbox"/> Yes <input type="checkbox"/> 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

Ohio Department of Health - School and Adolescent Health Immunization Report

Student's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
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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 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 (IPV or OPV)						
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						

Signature of Health Care Provider: _____ Date: _____
 (required)

RICHMOND HEIGHTS EMERGENCY MEDICAL AUTHORIZATION

STUDENT NAME/GRADE: _____

ADDRESS: _____ **CITY** _____ **ZIP** _____

DATE OF BIRTH _____ **E-MAIL** _____

LIVES with: Both Mom Dad Guardian

Has this address changed from last year (circle one)? yes no

PARENT CONTACT #1: DAD MOM OTHER

Name: _____

Home Address: _____ City _____ Zip _____

Home Phone: _____ Cell/Pager: _____

Work Phone: _____ Name of Employer: _____ Phone: _____

If Remarried, spouse name: _____

Which number should we call first (circle) HOME WORK CELL

PARENT CONTACT #2: DAD MOM OTHER

Name: _____

Home Address: _____ City _____ Zip _____

Home Phone: _____ Cell/Pager: _____

Work Phone: _____ Name of Employer: _____ Phone: _____

If Remarried, spouse name: _____

Which number should we call first (circle) HOME WORK CELL

In the event that reasonable attempts to contact me have been unsuccessful, the following persons are authorized to act for me on behalf of my son/daughter. (Permission must be granted by named parties.)

Name _____ Relationship _____

Day Phone _____

Name _____ Relationship _____

Day Phone _____

Name _____ Relationship _____

Day Phone _____

MEDICAL INFORMATION: List any medical conditions, allergies, current medications, and physical impairments to which a physician should be alerted:

TO GRANT CONSENT, THIS SECTION MUST BE COMPLETED

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

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Phone _____ (Emergency Room)

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 named doctors, or in the event the designated preferred practitioner 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 for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian _____ Date _____

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:

Signature of Parent/Guardian _____ Date _____