

Court Order Received _____
Proof Of Residency _____

DISTRICT ENROLLMENT FORM

New Philadelphia City Schools

Birth Certificate Verif. _____
Immunization Verif. _____

Building _____ Grade Level _____ Enrollment Date _____

***INFORMATION TO BE COPIED FROM LEGAL BIRTH CERTIFICATE: PLEASE PRINT**

*Legal Last Name _____ *Legal First Name _____

*Legal Middle Name _____ *Gender: MALE FEMALE

*Birth date _____ *Birth place (city,state) _____

Student Social Security # _____ Mother's Maiden Name _____

Address _____ City _____

State Ohio Zip Code _____ Phone (_____) _____ Check if unlisted

Last School Attended _____ School Address: _____

FIRST U.S.A. SCHOOL ATTENDED? Y N

City _____ State _____ Zip _____

Medical information the school should immediately know: _____

PLEASE CHECK INFORMATION BELOW:

Race/Ethnicity:

- White, Non-Hispanic
- Hispanic/Latino of any race
- American Indian or Alaska Native
- Asian
- Black or African American Non-Hispanic
- Native Hawaiian or Other Pacific Islander

Native Language/Dialect:

- English
- Spanish
- Indian
- Chinese
- Other _____
- Dialect _____

Citizenship:

- US
- Exchange Student
- Other (Non US Citizen)

Does Student Have/Receive:

- IEP
- MFE
- Title Services
- LEP Services

Handicap:

- Non Applicable
- 01-Multiple Disabilities
- 02-Deaf-Blindness
- 03-Hearing Impaired

Handicap (cont.):

- 04-Visual Impairment
- 05-Speech/Language
- 06-Orthopedic Impairment
- 08-Emotional Disturbance
- 09-Cognitive Disability
- 10-Specific Learning Disability
- 12-Autism
- 13-Traumatic Brain Injury
- 14-Other Health Impaired (Major)
- 15-Other Health Impaired (Minor)
- 16-Developmental Delay

PARENT/GUARDIAN RELATIONSHIP:

Mother/Guardian's Name _____

Address _____ Phone _____

Place of Employment _____ Phone _____

Father/Guardian's Name _____

Address _____ Phone _____

Place of Employment _____ Phone _____

Student lives with:

- Mother Father Foster Parent
- Step-Mother Step-Father Relative _____
- Guardian Grandparent Self Dependent

Parents/Guardians are:

- Married Single
- Divorced Separated
- Deceased

Is there a court order, judgement entry or custody papers concerning this student? Yes No

Has this student ever attended New Philadelphia Schools before? Yes No

If yes, what building? _____ When? _____

If this is an **Open Enrollment**, in what school district does the student reside? _____

Does student have other siblings? (name/grade) _____

Signature of Parent/Guardian or student if 18 or over: _____

Please Respond
in English

New Philadelphia City Schools HOME LANGUAGE SURVEY

English
Home Language Survey

Date _____ School _____ Grade _____

Child's Name _____
First Name Middle Initial Last Name

Parent or Guardian's Name _____
First Name Middle Initial Last Name

Address _____
Street City State Zip

Phone Number _____
Home Work

1. Was your child born in the United States? Yes No
If yes, in which state? _____
If no, in what other country? _____

2. Has your child attended any school in the United States for any three years during their lifetime? Yes No
If yes, please provide school name(s), state, and dates attended:
Name of School _____ State _____ Dates Attended _____
Name of School _____ State _____ Dates Attended _____
Name of School _____ State _____ Dates Attended _____

3. What is the language most frequently spoken at home? _____

4. If available, in what language would you prefer to receive communication from the school? _____

5. Please check if your child is:
A. Native American Indian C. Native Pacific Islander
B. Alaska Native D. Native U.S. Virgin Islander

6. Is your child's first-learned or home language anything other than English? Yes No

If you responded "Yes" to question number 6 above, please answer the following questions:

7. In what country did your child most recently reside? _____

8. Which language did your child learn when he/she first began to talk? _____

9. What language does your child most frequently speak at home? _____

10. What language do you most frequently speak to your child? (Father) _____
(Mother) _____

11. Please describe the language understood by your child. (Check only one)
A. Understands only the home language and no English.
B. Understands mostly the home language and some English.
C. Understands the home language and English equally.
D. Understands mostly English and some of the home language.
E. Understands only English.

Parent or Guardian's Signature

Date

OFFICE USE ONLY

Student ID #	Date Distributed	Date Received	
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NEW PHILADELPHIA CITY SCHOOLS HOUSING INFORMATION

This information will be kept in the strictest confidence and is solely provided for use by the New Philadelphia City School District.

Student Name: _____ Grade _____ Bldg: _____

Please check one of the following boxes which best describes your primary night time residence:

- I live with my parents/guardian in a residence we own/rent in New Philadelphia.
- I am a foreign exchange student or I attend New Philadelphia under Open Enrollment.
- We are staying in a shelter, church or emergency housing.
- We are staying with relatives/friends. This includes grandparents, aunts/uncles, family friends, boyfriend, girlfriend etc. . .
- We are staying in our car, a park or a campground.
- We are staying in a hotel/motel.
- We are staying in a bus/train station, an abandoned building, or a place not designed for, or ordinarily used as, regular sleeping accommodations.

PARENT/GUARDIAN SIGNATURE: _____



Transportation Registration Form

THIS FORM IS TO BE FILLED OUT ONLY IF ELIGIBLE FOR TRANSPORTATION

The following students are eligible for transportation:

School Year: _____

Students in grades K through 12 who reside with their legal guardian and live one mile or further from their assigned school of attendance will be assigned a designated pick-up and drop-off location. It is recommended that Kindergarten students have a parent or legal guardian present at the pick-up and drop-off location.

Student Name: _____ Parent Signature: _____

Phone #: (_____) _____ Listed Unlisted Cell Phone #: (_____) _____

Home/Mailing Address: _____
Street Number & Name City State Zip Code

Grade Attending: _____ Student Date of Birth: _____
Month Day Year

School Attending: Central East South West York
 NPHS WMS BCC STAR TCC TCC-EI.

Check One: AM ONLY PM ONLY BOTH AM & PM NO TRANSPORTATION

OFFICE USE ONLY

Established Stop: Yes _____ No _____ Starts On: _____

Entered on Route: Yes _____ No: _____ (If No – Need directions below)

Pick Up Time: _____ AM Bus Number: _____

Directions/Location: _____

Drop Off Time: _____ PM Bus Number: _____

Directions/Location: _____



New Philadelphia City Schools
248 Front Avenue S.W. New Philadelphia, OH 44663
Phone: (330) 364-0600 Fax: (330) 364-9310

Introduction: The United States Department of Education, under the No Child Left Behind Act, mandates that school districts collect and report racial and ethnic data. The purpose for collecting this information is to “ensure equal access” to education for all students. The New Philadelphia City School District is required to request this information from parents and then report it to the U.S. Department of Education.

Thank you in advance for your cooperation. Please direct questions about this form to your child’s building principal.

Directions: Please fill out the simple form below and return this entire page to your child’s school. A separate form is needed for each child.

Full Name of Child: _____

School Building: _____

Grade Level: _____

1. Is the child Hispanic/Latino? YES NO (Persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

2. Which of the following five racial groups applies to the child. Check all that apply:

- American Indian or Alaska Native** - Persons having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.
- Asian** - Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American** - Persons having origins in any of the black racial groups in Africa.
- Native Hawaiian or Other Pacific Islander**
- White** - People who have origins in any of the original peoples of Europe, North Africa, or the Middle East.

(The US Department of Education will allow educational entities to use “observer identification” of the race and ethnicity of elementary and secondary school students when self-identification or identification by the parents does not occur.)

Signature of Parent/Guardian: _____

Printed Name of Parent/Guardian: _____

Ohio School Health History

To be completed by parent or guardian

School _____
 Enrolled _____
 Withdrawn _____

Child's full name		Last	First	Middle
Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Birthdate	Month Day Year
Child's address				
Father's name				
Father's address				
Father's home phone		Father's work phone		Father's cell phone
Mother's name				
Mother's address				
Mother's home phone		Mother's work phone		Mother's cell phone
With whom does child live?		Name	Address	

FAMILY HISTORY

Please list this child's brothers and sisters

Name	Birth Year	Sex	Name	Birth Year	Sex
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

PERINATAL HISTORY

Did the mother have any unusual physical or emotional illness during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain briefly.		
How old was the mother When this child was born?	Was this infant born: <input type="checkbox"/> Full Term <input type="checkbox"/> Early <input type="checkbox"/> Late	What was this infant's birth weight?
Did the infant have any sickness or problems while in the nursery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain briefly.		

DEVELOPMENTAL HISTORY

Please give the approximate age at which this child: <input type="checkbox"/> walked alone _____ <input type="checkbox"/> was toilet trained _____	<input type="checkbox"/> spoke in sentences _____ <input type="checkbox"/> dressed self _____	How does this child's development compare to other children, such as his or her Brothers/sisters or playmates. <input type="checkbox"/> about the same <input type="checkbox"/> slower <input type="checkbox"/> faster
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Effective, Kindergarten 2006:

IMMUNIZATION RECORD

5-DPT, 4-Polio, 2-MMR, 3 Hepatitis B, 1 Varicella, 4-HIB

TYPE	DATE
DTaP/DPT/DT or Td	
Polio	
MMR Combined	
Hepatitis B	
Varicella Vaccine	
HIB (prior to age 5 only)	
Tuberculin Skin Test	
Other (Identify)	

Child Health History continued:

I. Health Conditions – Please check any that this child has had:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abnormal (spinal curvature, scoliosis, etc.) | <input type="checkbox"/> Concern about relation with siblings or friends | <input type="checkbox"/> Frequent sore throat infections | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Allergies or hayfever | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Heart disease, type _____ | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures or epilepsy |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney disease, type _____ | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Bedwetting at night | <input type="checkbox"/> Emotional | <input type="checkbox"/> Measles (“old fashioned” or “ten day”) | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Behavior problem | <input type="checkbox"/> Ear problems, poor hearing | <input type="checkbox"/> Meningitis or encephalitis | <input type="checkbox"/> Substance abuse (alcohol, drugs) |
| <input type="checkbox"/> Birth or congenital malformation | <input type="checkbox"/> Eye problems, poor vision | <input type="checkbox"/> Mumps | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Near-drowning or near-suffocation | <input type="checkbox"/> Toothaches or dental infections |
| <input type="checkbox"/> Chicken pox Date: _____ | <input type="checkbox"/> Frequent skin infections | <input type="checkbox"/> Nervous twitches or tics | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Chronic diarrhea or constipation | | <input type="checkbox"/> Poisoning | <input type="checkbox"/> Wetting during day |

II. Allergies – Please list and describe allergies or reactions to:

Medicines/drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

III. Injuries and Illnesses – Please list any severe injuries or illnesses:

Injuries/Illnesses	Age of Child	If Hospitalized <input checked="" type="checkbox"/>

Does child always wear seatbelts in cars? Yes No

IV. Additional Information

What medications are given daily?
What medications are given frequently, but not daily?

This child is usually: Very Active Normally Active Rather Inactive

Do you have any concern about how your child gets along with other children?
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Do you have other comments or concerns about this child’s health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly.
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Completed by:

Relationship to child:

Ohio School Health Record Dentist's Report

Child's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date
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The following services have been performed:		
<input type="checkbox"/> Examination	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Prescription for fluoride supplements
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Oral prophylaxis	<input type="checkbox"/> Topical application of fluoride

The following services have been performed:	
<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Diet counseling reflecting relation of diet to dental health
<input type="checkbox"/> Flossing	<input type="checkbox"/> Home/school use of fluoride mouthrinse

The following services have been performed:	
<input type="checkbox"/> All necessary services have been performed	<input type="checkbox"/> Diet counseling reflecting relation of diet to dental
<input type="checkbox"/> No restorative services are required at this time	<input type="checkbox"/> Further appointments have been arranged

Comments: _____ _____ _____ _____ _____ _____ _____ _____
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Please print or stamp

Dentist's Name	Dentist's Signature
Address	Date Signed
Phone	

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.
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.

Physician's Report

Child's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date
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Objective Data

Height (%)	Weight (%)	B.P. /
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Screening Test

Vision	Date	Hearing	Date
Distance Acuity right _____ left _____		Pure tone testing:	
Muscle Balance <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done		Right ear <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	
Farsightedness <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done		Left ear <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	
Color <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done		Other tests (specify) _____	
Child wears glasses? <input type="checkbox"/> yes <input type="checkbox"/> no		Child wears hearing aid? <input type="checkbox"/> yes <input type="checkbox"/> no	
Tested with glasses? <input type="checkbox"/> yes <input type="checkbox"/> no		Tested with hearing aid? <input type="checkbox"/> yes <input type="checkbox"/> no	
Referral made? <input type="checkbox"/> yes <input type="checkbox"/> no		Referral made? <input type="checkbox"/> yes <input type="checkbox"/> no	

Speech/Language

Speech assessment:	<input type="checkbox"/> done <input type="checkbox"/> not done <input type="checkbox"/> Child has no discernible speech problem
Child has possible problem with:	<input type="checkbox"/> Articulation <input type="checkbox"/> Rhythm <input type="checkbox"/> Voice <input type="checkbox"/> Language
Speech evaluation recommended:	<input type="checkbox"/> yes <input type="checkbox"/> no

Laboratory Test

<input type="checkbox"/> Hematocrit/Hemoglobin	<input type="checkbox"/> Urine protein	<input type="checkbox"/> Urine blood	<input type="checkbox"/> Urine glucose	<input type="checkbox"/> Other:
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Physical Examination:

Date examined:
<input type="checkbox"/> Essentially normal Abnormalities as follows: _____
Is this child able to participate fully in the following:
A. Classroom and academic activities? <input type="checkbox"/> yes <input type="checkbox"/> no C. Competition athletics? <input type="checkbox"/> yes <input type="checkbox"/> no
B. Physical education classes? <input type="checkbox"/> yes <input type="checkbox"/> no D. Contact and collision sports? <input type="checkbox"/> yes <input type="checkbox"/> no
If limitations are advised, please specify those limitations: _____
If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention? _____

Physician's Assessment

Problem list	Recommendation for school management
1.	1.
2.	2.
3.	3.

Please print or stamp

Physician's Name	Physician's Signature
Address	Date Signed
Phone	

Immunizations given this visit: