HEIR FORCE COMMUNITY SCHOOL

RE-ENROLLMENT FORM FOR 2016-2017 SCHOOL YEAR

STUDENT NAME: _____ GRADE:_____

ADDRESS: _____ CITY_____ STATE_____ZIP:_____

MOTHER'S NAME:_____FATHER'S NAME:_____

MOTHER'S PHONE# (HOME) _____(CELL)_____(WORK)_____

FATHER'S PHONE#: (HOME)_____(CELL)_____(WORK)_____

EMERGENCY CONTACT/AUTHORIZED PICK UP

NAME	PHONE	RELATIONSHIP TO CHILD

If there is anyone NOT authorized to pick your child up please let the office know

SCHOOL DISTRICT YOU LIVE IN: _____

HOW WILL YOUR CHILD BE TRANSPORTED? PLEASE CHECK ONE

_____BUS **(LIMA CITY & ELIDA DISTRICTS ONLY)(*Must live at least 1.5 miles from the school for Lima busing)***

_____PICK UP

_____WALKER **(Grades 3 thru 8 ONLY)**

_____OTHER (UMADOP, AFTERSCHOOL PROGRAMS, ETC.)

OFFICE USE ONLY: (ALL BOOK FEES ARE NON REFUNDABLE)

DATE $60 BOOK FEE PAID:	CASH By:	CHECK# By:

UNIFORM VOUCHER # (if applicable) _____ Date Given: _____ By: _____

Heir Force Community School
Student Medical 2/16

Name of Child:	Grade:	Date of Birth:	Gender:
			☐ Male ☐ Female

My child receives regular care for the following medical conditions:

__ No Medical Conditions.

__ **Yes. Please Check Below: (We must know for emergency medical purposes.)**

__ Allergic to any of the following: ***(Check All That Apply)***
- __ Bee Stings/Insect Bites
- __ Foods: _____
- __ Medication(s): _____
- __ Other: _____

__ Asthma __ Diabetes __ Heart Disease __ Sickle Cell Anemia
__ Cancer/Leukemia __ Hearing Problems __ Rheumatic Arthritis __ Vision Problems
__ Chronic Cough/Wheezing __ Hemophilia __ Seizures __ Autism
__ ADD __ ADHD __ Bipolar __ ED
__ ODD __ CD

__ **My child has or is currently receiving counceling and/or seeing a therapist.**
__ Other _____

__Takes the following medications (List all medications your child has currently been prescribed

Medication Name	*Dosage*	*Time Administered*

Family Physician:	***Phone Number:***
Family Dentist:	***Phone Number:***
Hospital:	***Phone Number:***

___The Heir Force Community School has my permission, in an emergency when I cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

___The Heir Force Community School DOES NOT have permission to transport my child to the hospital.

Parent/Guardian: _____
(PRINT)

Parent/Guardian Signature: _____ **Date:** _____

My signature acknowledges that as the Parent/Guardian, I understand that I am obligated to notify Heir Force Community School immediately if there is a change in any of the above information. I also understand that my signature is my acknowledgement and acceptance to all current and previous policy, rules and regulations.