HEIR FORCE COMMUNITY SCHOOL

RE-ENROLLMENT FORM FOR 2017-2018 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)**

_____UMADOP (M-Th) ← please pick a Friday dismissal option

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

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

Heir Force Community School
Student Medical 3/17

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.

March 17th, 2017

Dear Parent/Guardian,

This letter is to inform you that according to Ohio Revised Code 3314.041, your child(ren) will be taking proficiency tests and other examinations prescribed by law in the State of Ohio while he/she is here at Heir Force Community School.

This is also to inform you that according to Ohio Revised Code 3314.03(A)(11)(d), your child(ren) will be screened for the following tests: hearing, vision, speech, communications, medical problems, and developmental disorders sometime between the first day of school but before November 1 st .

If you have any questions regarding the above information, please call the school office at (419) 228-9241.

Thank you,

Darwin Lofton
Executive Director