

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:
			<input type="checkbox"/> Male <input type="checkbox"/> 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: _____

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Rheumatic Arthritis | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Chronic Cough/Wheezing | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Autism |
| <input type="checkbox"/> ADD | <input type="checkbox"/> ADHD | <input type="checkbox"/> Bipolar | <input type="checkbox"/> ED |
| <input type="checkbox"/> ODD | <input type="checkbox"/> CD | | |

My child has or is currently receiving **counseling 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.