

HEIR FORCE COMMUNITY SCHOOL

RE-ENROLLMENT FORM FOR 2018-2019 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:
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Heir Force Community School

Student Medical 3/18

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: _____

- | | | | |
|---|---|--|---|
| <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.

March 12th, 2018

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 1st .

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

Thank you,



Dr. Willie Heggins
Director Of Education