



Thurgood Marshall Leadership Academy

Student Enrollment Application

2013-2014
 2014-2015
 2015-2016
 2016-2017

Please Print

STUDENT INFORMATION

(Kindergarten students must be 5 by Dec 1)

Legal Name- Last, First, Middle		Named to be used in school		Grade	Birthdate (MM/DD/YY)	Sex <input type="checkbox"/> F <input type="checkbox"/> M
Street # and Name		City	Postal code	Apt.#	Home Phone #	Emergency #
Special Custody <input type="checkbox"/> Yes* <input type="checkbox"/> No <small>(If yes, please provide custody papers)</small>	Custody	Living With		Legal Guardian		

Is your child presently receiving any of the following services?

Title I
 Special Education/Please provide an IEP
 Free/Reduced Lunch

I will need transportation Yes No

First Parent/Guardian (or Father)	Second Parent/ Guardian (or Mother)
Relationship	Relationship
Name	Name
Address	Address
City and Zip code	City and zip Code
Home Phone #	Home Phone #
Cell Phone #	Cell Phone #
Business Phone #	Business Phone #

Siblings Currently Enrolled (N/A)

Name	Grade
_____	_____
_____	_____
_____	_____
_____	_____

Siblings Applying for Enrollment

Name	Grade Entering
_____	_____
_____	_____
_____	_____
_____	_____

Your child's application will not be accepted until the above information is submitted with this completed application form. Upon enrollment, you will be asked to provide additional forms, including the original copies of these documents, complete up-to-date health records, including immunization records, and the most recent report card, I.E.P. as applicable, and test scores.

Legible photocopies of the following documents must be submitted at the time of enrollment before the start of school.

Enrollment Check List

- Student's Birth Certificate _____ Legal Guardianship Papers (If Applicable) _____
- Home Utility Bill, Mortgage Bill or Lease to verify Indiana residency _____
- Parent/Guardian State of Indiana License or Identification Card _____ Student's Social Security Card _____
- Updated, Current Physical (Mandatory for ALL grades) and Immunization Record _____

Student's Name:	1) ID#
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EMERGENCY INFORMATION

240) 1 st Emergency Contact Name (Not Parent or Guardian)		241) 1 st Contact Phone # ()		242) 1st Cont Ext #
U40) 2 nd Emergency Contact Name (Not Parent or Guardian)		U86) 2 nd Contact Phone # ()		U60) 2 nd Cont Ext.#
244) Sitter/Daycare Name	246) Address	247) R.R.#	245) Phone Number # ()	257) Ext. #
260/261) Medical Problems				
262/263) Disabilities				
268/269) Emergency Comment				
264) Health Card Number# (optional)		270) Health Card Revision# (optional)		
266) Doctor's Name		267) Doctor's Phone # ()		

STUDENT HISTORY

U55) Home School (If attending on transfer)	U7) Transfer Reason
201) Resident Yes <input type="checkbox"/> No <input type="checkbox"/> Specify _____	204) Name of Previous School
Full Mailing Address of Previous School	
Phone Number of Previous School ()	Date Last Attended Previous School (YY/MM/DD)

NOTICE TO PARENTS

Has your child ever been expelled from another school? Yes No If yes, was the student re-admitted? Yes No

Is this student currently under suspension from any school? Yes No

Information is collected pursuant to the Education Act. It may be disclosed beyond the Board for purposes such as:

- + School Councils, class lists, emergency phone networks, Student council, etc.
- + In case of an accident or witness to an accident, the student's name and home address will be released to the Board's insurer.
- + The release of names, ages, grades, with photographs, artwork, writing or other school work to the media for publicity.
- + The use of names, photographs, etc. used for displays in the school, newsletters and yearbooks.

If you do not consent to the release of information for these purposes, please inform the principal in writing within 20 days.

I hereby certify that the above information is accurate to the best of my knowledge.

Signed (Parent/Guardian)

Date



HEALTH SERVICES DEPARTMENT

Personal Health History

2013-2014 2014-2015 2015-2016 2016-2017

Please give details for all that are marked YES on side one that may impact your child's routine at school.

An additional, specific "Individual Health Care Plans" should be in place for students with Asthma, Diabetes, Seizures, Food Allergies, Insect Sting Allergies, Cancer, Hemophilia and other special health conditions. Many of these plans require doctor's signatures. Please contact your school nurse as soon as possible to complete the plans. Plans should be completed and in place before the first day of school.

Additional Health Information

EMERGENCY INFORMATION: My child may require the following emergency medications during school hours:

Diastat for seizures Epi-pen for allergic reaction Emergency asthma inhaler/nebulizer treatment

My child was hospitalized overnight IN THE LAST YEAR: Date: _____ Reason _____

Most medications may be taken at home. Will your child be required by a physician to take medication during school hours? Yes NO
All medication taken at school will require an additional signed medication permit on file PRIOR to giving medication at school.

List ALL Medication/s your child takes on a daily basis.

Medication Name	Amount	Time Taken	Doctor Prescribing Medication for this Condition
1.			
2.			
3.			
4.			

- 1.
- 2.
- 3.
- 4.



HEALTH SERVICES DEPARTMENT

Personal Health History

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Student's name:

Last First M. Primary Address: Street City Zip Grade Primary Language: Gender: Male Female
Student lives with: BOTH PARENTS MOTHER FATHER OTHER-EXPLAIN
Primary Parents/Guardian: Last First M. Work/Home Phone: Cell Phone: E-Mail:
Mother/Guardian: Last First M. Work/Home Phone: Cell Phone: E-Mail:
Daytime Phone: Cell Phone: E-Mail:
Father/Guardian: Last First M. Work/Home Phone: Cell Phone: E-Mail:
Daytime Phone: Cell Phone: E-Mail:

MEDICAL

Does your child have a doctor? Yes No Medical Coverage: Private Medicaid/Health Wise No Insurance
Physician's name Phone: Hospital Preference:

MEDICAL HISTORY I have been told by a Physician or Health Care Professional that my child has the following condition/s (CHECK ALL THAT APPLY AND LIST ADDITIONAL INFORMATION ON OTHER SIDE)

- Asthma Exercise Induced Asthma ADD ADED On ADD/ADHD Medications Deafness Hearing aids Blindness Glasses Last exam:
Autism Asperger's Syndrome Bladder/Kidney concerns-explain on other side Food intolerance-explain on other side Lactose Intolerance
Blood/Clotting Hemophilia Van Willebrand Cancer Leukemia Other-explain on other side Head Injury Concussion Date:
Crohn's disease Stomach/Bowel disease-explain on other side Cancer Leukemia Other-explain on other side
Heart disease Murrur as infant recent or under treatment Date:
Heart problem with restrictions-explain on other side
Lung Disease-explain on other side
Tuberculosis (latent) (active) Currently taking TB medications
Stickle Cell disease trait
Seizures from fever Epilepsy Unspecified Shunt
Frequent Headaches (nonspecific) Migraine (requiring medication)
Psychological/Psychiatric - list medications and specific diagnosis on the back of this form Other Allergy
Depression Anxiety OCD Other:
Diabetes Type Type II Metabolic Syndrome
Prosthesis Eye Leg Arm
Diet Restrictions-explain on other side
Eating Disorder Obesity Underweight Anorexia