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 ☐ F ☐ M

Street # and Name	City	Postal code	Apt.#	Home Phone #	Emergency #

Special Custody ☐ Yes* ☐ No (If yes, please provide custody papers)	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#

EMERGENCY INFORMATION

240) 1st Emergency Contact Name (Not Parent or Guardian)		241) 1st Contact Phone # ( )		242) 1st Cont Ext #
U40) 2nd Emergency Contact Name (Not Parent or Guardian)		U36) 2nd Contact Phone # ( )		U60) 2nd 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 ☐ No ☐ 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 _____

THURGOOD MARSHALL
High Expectations. No Excuses.

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.			

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Student's name:

_____
Last *First* *M.*

Grade _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Primary Language: _____

Primary Address: _____
Street *City* *Zip*

Student lives with: ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER:EXPLAIN

Primary Parents/Guardian:

Mother/Guardian: _____
Last *First* *M.*

Daytime Phone: _____ Work/Home Phone: _____ Cell Phone: _____ E-Mail: _____

Father/Guardian: _____
Last *First* *M.*

Daytime Phone: _____ Work/Home Phone: _____ Cell Phone: _____ E-Mail: _____

MEDICAL

Does your child have a doctor? ☐ Yes ☐ No Medical Coverage: ☐ Private ☐ Medicaid/Hoosier 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 ☐ ADHD ☐ 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 ☐ Murmur ☐ 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
☐ Sickle 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
☐ 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

ALLERGIES (Check all that apply to your child)

☐ Insect/Bee Sting allergy ☐ Local (swelling at sting site only) ☐ Sting Requires hospital/ Epi Pen
☐ Latex - requiring hospital/ Epi Pen ☐ Latex (not life-threatening)
☐ Food -life threatening - ☐ requiring Epi Pen (LIST FOOD ALLERGIES ON OTHER SIDE)
☐ Medications/s Allergy (LIST MEDICATION ALLERGIES ON OTHER SIDE)
☐ Seasonal (requiring medication) ☐ Hay fever (requiring medication)
☐ Animals (LIST ANIMAL ALLERGIES ON OTHER SIDE)
☐ Other Allergy _____
☐ My child has had Chickenpox Disease (not vaccine) ☐ Yes ☐ No Date: