

Charter Community School Programs Enrollment Form

(To be completed by the parent or guardian)

Office Use Only:

Type: A B C
Program: CCS CDS
EDT HSA I II III

Anticipated Start Date in Charter Program: _____ Grade

Student's LEGAL Name: _____ Date of Birth: _____ Male
(from birth certificate) Last Name First Name Middle Name Mo./Day/Year Female

Mother's/Guardian's First Name Last Name Home Phone Cell/Work Phone

Father's/Guardian's First Name Last Name Home Phone Cell/Work Phone

Mailing Address City State Zip

Residence Address (IF DIFFERENT) City State Zip

School District in which you live _____

Last School Attended: _____ Last Day of Attendance _____
Name of School City/State Phone No.

ETHNICITY: Mark the ethnicity with which the student most closely identifies: Please check one:

- Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)
 Not Hispanic or Latino

WHAT IS YOUR CHILD'S RACE (Please check up to five racial categories) The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> American Indian or Alaskan Native (100)
(Person having origins in any of the original people of North and South America (including Central America) | <input type="checkbox"/> Korean (203)
<input type="checkbox"/> Vietnamese (204)
<input type="checkbox"/> Asian Indian (205)
<input type="checkbox"/> Laotian (206)
<input type="checkbox"/> Cambodian (207)
<input type="checkbox"/> Hmong (208)
<input type="checkbox"/> Other Asian (299) | <input type="checkbox"/> Hawaiian (301)
<input type="checkbox"/> Guamanian (302)
<input type="checkbox"/> Samoan (303)
<input type="checkbox"/> Tahitian (304)
<input type="checkbox"/> Other Pacific Islander (399) | <input type="checkbox"/> African American or Black (600)
<input type="checkbox"/> White (700)
(Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East) |
| <input type="checkbox"/> Chinese (201)
<input type="checkbox"/> Japanese (202) | | | |

RESIDENCE – where is your child/family currently living? (Federally mandated by NCLB: Please check appropriate box)

- | | |
|--|---|
| <input type="checkbox"/> In a single family permanent residence (house, apartment, condo, mobile home) | <input type="checkbox"/> In a motel/hotel |
| <input type="checkbox"/> Doubled-up (sharing housing with other families/individuals due to economic hardship, loss, or other reasons) | <input type="checkbox"/> Unsheltered (car/campsite) |
| <input type="checkbox"/> In a sheltered or transitional housing program | <input type="checkbox"/> Other _____ |

OTHER CHILDREN IN THE FAMILY:

First and Last Name	Relationship	Lives at Home	School	Grade (If graduated, not applicable)
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____

OTHER ADULTS IN THE HOME:

Name	Relationship	Name	Relationship
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PARENT EDUCATION LEVEL: Check the response that describes the highest education level of parent/guardian(s):

- | | | |
|---|--|---|
| <input type="checkbox"/> Not a high school graduate | <input type="checkbox"/> Some college (includes AA degree) | <input type="checkbox"/> Graduate school/post graduate training |
| <input type="checkbox"/> High school graduate | <input type="checkbox"/> College graduate | |

What special services has your child received? (Please check all boxes that apply)

- Special Education:** Resource (RSP) Special Day Class (SDC) Speech/Language 504 Accommodation Plan
Other: Gifted (GATE) Remedial Math Remedial Reading Counseling English Language Development
 Medical Health Plan

Has the student been expelled or is the student in the process of being expelled from any school? Yes No

HEALTH PROBLEMS (Check all that apply)

- Diagnosed ADD or ADHD.....
- Asthma.....
- Bladder Problems.....
- Bleeding Disorder.....
- Color Vision Deficiency.....
- Diabetes.....
- Eczema/Skin Trouble.....
- History of Ear Problem.....
- Heart Problem.....
- Head Injury.....
- History of Fractures.....
- History of Hospitalization.....
- History of Surgery.....
- Known Hearing Loss.....
- Known Vision Loss.....
- Physical Limitations.....
- Wears Contact Lens.....
- Wears Glasses.....

- Epilepsy.....
- Eye Injury.....
- Hypoglycemia.....
- Frequent Nosebleeds.....
- Scoliosis.....
- Seizure Disorder.....
- Chicken Pox.....

Describe _____
 Describe _____
 Describe _____
 Describe _____
 Describe _____
 Describe _____
 Describe _____
 Right Left
 Right Left
 Describe _____

For close work For distance only At all times

Other or further details of above _____

ALLERGIES (Check all that apply)

- Animals
- Insects
- Bee Stings
- Drugs
- Food
- Plants
- Other

None:
 List specific item(s) student is allergic to: _____
 Describe allergic reaction and/or treatment: _____
 Explain: _____

CURRENT MEDICATION(S) No Yes Epi-Pen If medication is needed at school a medication consent form must be picked up from the office and completed. Please list below:

Name of Medication(s)	Dosage	Time Taken	Purpose
_____	_____	_____	_____
_____	_____	_____	_____

I/We give permission for my/our student to be observed, interviewed, photographed and/or filmed when a representative of the media has been permitted by the principal or designee to be on campus. I/We also give permission for the Charter Alternative Programs to use pictures and other digital media of my/our student in print or online for program publications, reports, demonstrations, websites, or similar. Yes___ No___

EMERGENCY MEDICAL AUTHORIZATION

I am/we are the parent/guardian of the above named student. In case I am/we are unable to be reached during any emergency, I/we hereby authorize a representative of the school, pursuant to the provisions of Family Code Section 6910, to act as any agent to consent to the giving of any and all medical, dental, hospital or surgical care to the above named student.

I/We have reviewed this two page document and to the best of my/our knowledge, the information contained herein is true and complete. The undersigned declares under penalty of perjury that they are the parents or legal guardians of the above-named student and grant the above authorizations.

Date: _____ Signature of Parent/Guardian: _____

Revised: 2/23/12