

# Charter Alternative Programs Enrollment Form

(To be completed by the parent or guardian)

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

\_\_\_\_\_  
Mother/Guardian Email Address / Father/Guardian Email address

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

## **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.....	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	Eye Injury.....	<input type="checkbox"/>
Bladder Problems.....	<input type="checkbox"/>	Hypoglycemia.....	<input type="checkbox"/>
Bleeding Disorder.....	<input type="checkbox"/>	Frequent Nosebleeds.....	<input type="checkbox"/>
Color Vision Deficiency.....	<input type="checkbox"/>	Scoliosis.....	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	Seizure Disorder.....	<input type="checkbox"/>
Eczema/Skin Trouble.....	<input type="checkbox"/>	Chicken Pox.....	<input type="checkbox"/>
History of Ear Problem.....	<input type="checkbox"/>	Describe.....	
Heart Problem.....	<input type="checkbox"/>	Describe.....	
Head Injury.....	<input type="checkbox"/>	Describe.....	
History of Fractures.....	<input type="checkbox"/>	Describe.....	
History of Hospitalization.....	<input type="checkbox"/>	Describe.....	
History of Surgery.....	<input type="checkbox"/>	Describe.....	
Known Hearing Loss.....	<input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>	
Known Vision Loss.....	<input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>	
Physical Limitations.....	<input type="checkbox"/>	Describe.....	
Wears Contact Lens.....	<input type="checkbox"/>		
Wears Glasses.....	<input type="checkbox"/>	For close work <input type="checkbox"/> For distance only <input type="checkbox"/> At all times <input type="checkbox"/>	

Other or further details of above \_\_\_\_\_

**ALLERGIES (Check all that apply)**

None: ☐  
Animals ☐ Drugs ☐ List specific item(s) student is allergic to: \_\_\_\_\_  
Insects ☐ Food ☐  
Bee Stings ☐ Plants ☐ Describe allergic reaction and/or treatment: \_\_\_\_\_  
Other ☐ 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 and the El Dorado County Office of Education (EDCOE) to use pictures and other digital media, including video, of my/our student for any lawful purpose – e.g., in print or online, including publications, websites, and advertisements. 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:** \_\_\_\_\_