CARONDELET
LEADERSHIP ACADEMY

NEW STUDENT ENROLLMENT

Student Information

Last Name **First Name** **Middle Name**

Street Address **Apt.#** **City** **State** **Zip**

Date of Birth: _____ **Social Security Number:** _____ **Applying Grade:** _____

Gender: M F **Student Lives With:** Both Parents Mom Dad Guardian Foster Home Other _____

Ethnicity: ____ Black/African American ____ White/Caucasian _____Hispanic/Latin ____ Asian/Pacific Islander

____ American Indian/Alaskan Native ____ Multi-Racial ____ Other _____

Primary Household

PARENT/GUARDIAN WITH WHOM STUDENT RESIDES

Last Name **First Name** **Relationship**

Street Address **Apt.#** **City** **State** **Zip**

Home Phone **Cell Phone** **Work Phone**

Email Address

OTHER PARENT/GUARDIAN WITH WHOM STUDENT RESIDES

Last Name **First Name** **Relationship**

Home Phone **Cell Phone** **Work Phone**

Email Address

Secondary Household

PARENT/GUARDIAN WITH WHOM STUDENT DOES **NOT** RESIDES

Last Name First Name Relationship

Street Address Apt.# City State Zip

Home Phone Cell Phone Work Phone

Sibling Information

LIST BROTHER(S)/SISTER(S)

Last Name First Name Grade School Name

Last Name First Name Grade School Name

Last Name First Name Grade School Name

Previous School's Information

School's Name City State Grade(s) Attending

School's Name City State Grade(s) Attending

School's Name City State Grade(s) Attending

Is your child currently suspended / expelled from any school in this state or any other state? Yes No

If yes, please explain. _____

_____

Emergency Information and Treatment

I authorize Carondelet Leadership Academy to release my child to the following adults:

Last Name First Name Relationship

Home Phone Cell Phone Work Phone

Last Name First Name Relationship

Home Phone Cell Phone Work Phone

I give Carondelet Leadership Academy permission to seek medical treatment for my child in the event of a medical emergency. I will be responsible for the cost of any emergency medical care provided to my child.

My preferred hospital is: _____

Parent/Guardian Signature _____ Date _____

Homeless Status

YES NO Are you sharing the housing of other persons due to loss of housing, economic hardship or a similar reason?

YES NO Are you currently residing at a motel, hotel, in a car, or at a campsite, because your home has been damaged or because of economic reasons?

YES NO Are you currently residing in a shelter?

YES NO Are you currently living in a temporary housing arrangement due to economic hardship?

Home Language Survey

YES NO Does the student speak a language other than English as a primary form of communication?

If yes, Language._____

YES NO Is a language other than English spoken in the home as a form of communication?

If yes, Language. _____

YES NO Has your child ever been in a bilingual or English as a Second Language (ESL) program?

If yes, how many years?_____

Student Services Intake Information

YES NO Has your child been screened for special education by the public schools?

YES NO Was the previous school considering or investigating whether your child has a disability?

YES NO Has your child received special education services under the Individuals with Disabilities Education?

YES NO Does your child have a current Individual Educational Plan (IEP)? If yes, please provide a copy.

YES NO Does your child receive services under Section 504 of the Rehabilitation Act of 1973? If yes, please provide a copy of the most recent Individual Accommodation Plan (IAP) and evaluation.

YES NO Is your child currently receiving Title I or Remedial Reading Services?

YES NO Is your child currently receiving Formal Gifted Program Services?

Migratory Status

If you have moved from one school district to another in the past six years, please answer the following questions; they will help us determine whether your child is eligible for a special program of supplemental services.

YES NO Before the move, was either parent (or guardian) employed in some form of temporary or seasonal agricultural or Agriculture-related work (planting or harvesting crops, landscaping, transporting farm products to market, processing meat or vegetables, etc.)?

YES NO Was the move from one school district to another made for the purpose of looking for or obtaining any of the above jobs?

YES NO Is either parent (or guardian) now employed in any of the above kinds of work?

YES NO Have you moved away with your child during only the summer months to work in seasonal agriculture?

Military

A Military Connected Student is a student residing in the house of a person (family) who is on active duty or serving in the reserve component of a branch of the United States Armed Forces. Include children who are living with family due to parents being deployed. Check one:

_____ Not Military Connected _____ Active Duty _____ National Guard or Reserve

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Please place an "X" in the box next to any of the following items if appropriate. Otherwise, it is assumed if you grant permission for CLA to release or use the information as specified.

☐ **CLA MAY NOT release my child's directory information.**
Under Federal Education Rights and Privacy Act, public school districts are allowed to release basic directory information which is student's name, grade level, parent/guardian names, address, telephone number, date of birth, major field of study, participation in activities and sports including audiovisual or photographic records or the openly visible activities thereof, weight and height of members of athletic teams, dates of attendance, degrees and awards received, most recent school attended by student, enrollment status, photographs including photographs of regular school activities that do not disclose specific academic information about the child and/or would not be considered harmful or an invasion of privacy. **If you do not wish for this information to be released, please put an "X" in the corresponding box.**

☐ **My child MAY NOT be photographed and/or taped for publication or public use. I understand this includes school pictures and yearbook. Denial of permission does not affect the district's authority to use video cameras for law enforcement and discipline purposes. You do not wish your student to be photographed or videotaped at school or during school activities.** This includes annual school pictures and electronic images to be published in school publication for electronic media. This also means your child will not appear in the yearbook and on CLA websites.

☐ **Medical/health concerns related to my child MAY NOT be disclosed to school staff. You do not wish the school nurse to report your child's health issues/problems to the administrators/teachers and other district staff who work with him/her.** Please be aware denial of this information to the staff working with your child could cause serious consequences in the event of an emergency.

I acknowledge that all of the information on these pages is true and accurate.

_____ _____

Signature of Parent/Legal Guardian Date

Health History Form

GRADE

NAME	BIRTHDATE	SEX

ADDRESS

FATHER/GUARDIAN	PRIMARY PHONE	ALTERNATE PHONE
MOTHER/GUARDIAN	PRIMARY PHONE	ALTERNATE PHONE
EMERGENCY CONTACT (NAME & PHONE)		RELATIONSHIP TO CHILD

Please circle any of the following that affect your child:

Asthma	Allergies	Diabetes
Blood Disorders	Ear Problems	Vision Problems
Seizures	Heart Problems	Emotional Problems
Skin Diseases	Frequent Sore Throats	Kidney Problems

Explain all of the circled items:

_____

_____

List any allergies that affect your child:

_____

List any hospitalizations; when and what for?

_____

List any surgeries; when and what for?

_____

Medications: List all prescribed medications or any other taken on a regular basis?

_____

_____

EMERGENCY ACTION needed for your child's health condition whileat school? Yes No (circle one)

If yes describe: _____

_____

Any other medical issue the school should know aboutthis student? Yes No (circle one)

If yes describe: _____

_____

Do you authorize this information to be shared with appropriate school personnel? Yes No (circle one)

Parent/Guardian Signature_____**Date**_____

CARONDELET
LEADERSHIP ACADEMY

7604 Michigan Avenue ~ St. Louis, MO 63111 Phone: 314-802-8744 Fax: 314-802-8721

Student Name _____ 18/19 Grade _____ DOB _____

CONSENT FOR THE RELEASE OF INFORMATION

Date of Request: _____

Carondelet Leadership Academy requests information from:

School/Organization/Etc: _____

Address: _____

City:_____State:_____Zip: _____

Phone:_____Fax: _____

Information to be released:

_____ Cumulative permanent school records including

1. Grades up to and at the time of withdrawal
2. Achievement test scores with the name of tests and dates given
3. Attendance records
4. Discipline records

_____ Health information, including complete record of immunizations

_____ Psychological/Medical reports if needed for educational placement

_____ If applicable, Special Education records (current IEP and reevaluations)

_____ If applicable, Section 504 Plan and related evaluations

_____ Last date of attendance at your school: _____

_____ Other (Specify) _____

This information is being obtained for educational purposes.

Your signature grants the sending school permission to forward your child's school records to Carondelet Leadership Academy.

Parent/Guardian Signature: _____ Date: _____

The State of Missouri requires that any school district, which receives a request for educational records from another school district enrolling a pupil who had previously attended a school in the district from which the student is transferring, will respond to such request within five business days of receiving the request with or without a parent's signature.

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PARENT PERMISSION TO GIVE OCCASIONAL OVER-THE-COUNTER MEDICATION

Student Name _____ Grade _____

Over-the-counter (OTC) medications are drugs that do not require a prescription and are purchased "over-the-counter." This form is required before over-the-counter medications can be administered at school.

PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

_____ I approve all medications listed below

_____ I do not want any OTC meds given to my student

ORAL

_____ Ibuprofen (i.e. Advil, Motrin, Nuprin)

_____ Antacid (i.e.Tums)

_____ Antihistamine (i.e. Benadryl)

OTC medications will be given at the manufacturer's recommended dosage.

THE MEDICATIONS INDICATED ABOVE MAY BE ADMINISTERED TO MY STUDENT

_____

(Signature of Parent or Guardian) (Date)

*The school is not able to supply medication for frequent or daily use.