

Maple Heights City Schools

ENROLLMENT OFFICE

5500 Clement Drive

Maple Heights, Ohio 44137

MARY BROWN
ENROLLMENT/TRUANCY OFFICER

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KINDERGARTEN REGISTRATION PACKET for the 2010-2011 School Year

Kindergarten Registration is being held Monday, April 12 through Friday, April 16, from 8:00 a.m. until 2:30 p.m. each day, by appointment only at the district Enrollment Office located at Maple Heights High School, 5500 Clement Drive. This registration packet is to be completed prior to your appointment.

The following items are required to complete the enrollment process:

- ✓ **Birth Certificate** – Original or certified copy (*child must be 5 by 9/30/10 to enroll*)
- ✓ **Social Security Card or Number**
- ✓ **Custody Papers** – A signed and certified copy (if applicable)
- ✓ **Complete Immunization Record**
- ✓ **Parent/Guardian Ohio Driver's License or State I.D.**
- ✓ **Child's Medicaid Number** (if applicable)
- ✓ **IEP/ ETR / MFE** – If child receives special education services
- ✓ **Proof of Residency** – At least three different, recently dated items showing your name at your current Maple Heights address will be required. Such documents include, but are not limited to:

___ Voter Registration Card

___ Utility Bills

___ Valid State Driver's License/I.D

___ Cable/Cell Phone Bills

___ City of Maple Hts. Occupancy Permit

___ Bank Statement

___ Mortgage Statement or Deed

___ Credit Card Statements

___ Section 8 Contract

___ Pay Stub Renter's Insurance

___ Valid Signed Lease

___ County Benefit Vouchers

___ Car/Home Insurance or Renter's Insurance

___ Municipal Income Tax Records

**Please call the enrollment office at 587-3200, ext. 1030 or 1031
with any questions or concerns and to schedule your appointment.**

- New
 Re-entry

Maple Heights City School District



STUDENT REGISTRATION FORM

School RAYMOND SCHOOL

Grade KINDERGARTEN

Student Name	Last Name _____	First Name _____	Middle Name _____	Entry Grade _____
Social Security # <small>(optional)</small>	_____ - _____	Birth Date	Month _____ Day _____ Year _____	
Student's Home Address	Number _____ Street _____	City _____	Zip Code _____	Up <input type="checkbox"/> Down <input type="checkbox"/> Apt. # _____
Parent/Guardian	Name _____		Phone Number _____	
Previous school attended <small>• Kindergarten include preschool if attended • Include homeschooling</small>	Name of School _____		School District _____	City _____ State _____

Is this student Hispanic/Latino? <input type="checkbox"/> No, not Hispanic/Latino <input type="checkbox"/> Yes, Hispanic/Latino	Race <small>(choose one or more)</small> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	How Identified: _____
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Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Citizenship <input type="checkbox"/> Dual National <input type="checkbox"/> Non-Resident Alien <input type="checkbox"/> Resident Alien <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Other please name: _____
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Birthplace City _____ State _____ Country _____	Native / Primary Language <input type="checkbox"/> English <input type="checkbox"/> Other please name: _____
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Student Lives With (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Parent <input type="checkbox"/> Other (explain): _____	<input type="checkbox"/> Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Self
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Legal Custody (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent Court Journal Entry: (____ / ____ / ____) County: _____	<input type="checkbox"/> Guardian <input type="checkbox"/> CCDCFS <input type="checkbox"/> Other (explain): _____ <input type="checkbox"/> Probate Court <input type="checkbox"/> Juvenile Court Restrictions: _____ District Bearing Cost(for Foster Children only): _____
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Is the child in gifted or Advanced Placement?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, describe services:
Does the child have a 504 plan?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, describe services:
Has the child ever had an IEP?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, list year of most recent evaluation:
If yes, do you have a copy of the IEP?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, indicate program:
Is the child suspended?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, from what district?
Is the child expelled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, from what district? End Date: _____

I do not consent to the release of email, home address, and home phone number for outreach purposes

PARENT(S) / GUARDIAN INFORMATION

STUDENT NAME: _____

Mother		<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Remarried	<input type="checkbox"/> Deceased
<input type="checkbox"/> Residential <input type="checkbox"/> Non-Residential		Dual Mailing: <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Name		First Name		
Number		Street		City		Zip Code	
Address							
Workplace				Email			
Home Phone			Work Phone			Cellular Phone	

Father		<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Remarried	<input type="checkbox"/> Deceased
<input type="checkbox"/> Residential <input type="checkbox"/> Non-Residential		Dual Mailing: <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Name		First Name		
Number		Street		City		Zip Code	
Address							
Workplace				Email			
Home Phone			Work Phone			Cellular Phone	

Legal Guardian		<input type="checkbox"/> Step Parent	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Other:			
Last Name				First Name			
Number		Street		City		Zip Code	
Address							
Workplace				Email			
Home Phone			Work Phone			Cellular Phone	

Social Worker (If Applicable): _____

EMERGENCY CONTACT INFORMATION

Name		Relationship		Name		Relationship	
Telephone				Telephone			
Address				Address			
Email				Email			

PLEASE LIST ALL OTHER CHILDREN UNDER THE AGE OF 22 WHO LIVE AT THE HOME ADDRESS

Name	Grade	Date of Birth	Gender	Relationship To Student

I hereby certify, under penalty of perjury, that all of the information that I have given is correct in all respects to the best of my knowledge.

Date: _____ **Parent/Legal Guardian/Independent Student:** _____

Signature

Maple Heights City School District



Date: _____

Home Language Survey

Federal guidelines require that this form be completed for all enrolled students.

School: _____ Grade: _____ Gender: Male Female

Student Name: _____ Birthdate: _____ Country of Birth: _____

Home Address: _____
(Street) (City) (Zip)

Parent/Guardian Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Please answer the following questions:

1. What language did your child speak when first learning to talk? _____
2. What language does your child speak most often at home? _____
3. What language do you use most frequently when communicating with your child? _____
4. List the language(s), other than English, spoken by your child _____
5. List the language(s), other than English, spoken in the home. _____

PARENT/GUARDIAN SIGNATURE: _____

If your answer was any language other than English to questions 1-5, please answer the following questions.

6. What is the Parent/Guardian's native language? Mother _____ Father _____ Guardian _____
7. Does your child: speak English read English write English *(Check all that apply.)*
8. Which adults in the home **speak** English? Mother Father Guardian
9. Which adults in the home **read** English? Mother Father Guardian
10. Do you need an interpreter? Yes No If yes, do you have one available? Yes No
11. Interpreter's Name (If available): _____ Phone #: _____
12. When did your child first attend school in the United States? Date: _____

13. List the schools your child attended in the United States

School Name	City/State	Grade	Dates Enrolled

14. List the schools your child attended in another country

School Name	City/Country	Grade	Dates Enrolled

Maple Heights City Schools Emergency Medical Authorization

Student Name _____ Grade _____ DOB _____

Address _____ Phone # _____ / _____

Please list all names and phone numbers of people we can call if your child becomes ill and needs to go home.

Mother's Name _____ Phone _____ / _____ / _____
Home Work Cell

Father's Name _____ Phone _____ / _____ / _____
Home Work Cell

Other Person's Name/Relationship _____

Address _____ Phone _____ / _____ / _____
Home Work Cell

Other Person's Name/Relationship _____

Address _____ Phone _____ / _____ / _____
Home Work Cell

Other Person's Name/Relationship _____

Address _____ Phone _____ / _____ / _____
Home Work Cell

PURPOSE: TO ENABLE PARENTS TO AUTHORIZE THE EMERGENCY TREATMENT FOR CHILDREN WHO BECOME ILL OR INJURED WHILE UNDER SCHOOL AUTHORITY WHEN PARENTS CANNOT BE REACHED.

PART I or PART II MUST BE COMPLETED!

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospitals to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Phone _____

In the event reasonable attempts to contact me at _____ or _____ at _____
phone number other parent phone number

have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. _____
preferred doctor or Dr. _____ preferred dentist, or in the event the designated preferred practitioner is not available, by

another licensed physician or dentist; and (2) the transfer of the child to _____ or any reasonably accessible.
Preferred hospital

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted _____

Date Signature of Parent Address

PART II – REFUSAL OF CONSENT

I DO NOT GIVE MY CONSENT for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take NO action or to: _____

Date Signature of Parent Address

Maple Heights City School District



RESIDENCY AND CUSTODY AFFIDAVIT

For the purpose of establishing school residence and custody (To be completed by parent or legal guardian)

SIGN ONLY AFTER CAREFULLY READING AND SIGNING IN THE PRESENCE OF A NOTARY

THE UNDERSIGNED, FIRST BEING DULY SWORN ACCORDING TO LAW, STATE THAT:

I, _____ certify that I am the custodial parent/legal guardian of
(Parent's or Legal Guardian's Full Name)

(Student's Name)

and that I have established residency at _____
(Street Number, Name, Apt. #) (City) (State) (Zip Code)

Date of Occupancy: _____ Lease End Date (if applicable): _____

I, _____, certify that I am a resident of the above residence located within **Maple Heights City School District**. The registrar has explained to me that legal residency is determined by certain conditions, among them are that mail delivery, voting residence, and payroll city tax deductions are based on the **Maple Heights City School District** address and also, that the residence where meals are taken, and where the resident parent sleeps must be at the **Maple Heights City School District residence**. This is the legal definition of residency for school purposes in Ohio. See Ohio Revised Code Sections 3301.121, 3313.66 through 3313.662.

List the names of **ALL** people, both adults and children, who reside at the above address. Also, please indicate their school (if applicable) and "status" (i.e., homeowner, lessee, renter, parent, guardian, student, preschooler, grandparent, etc.) Attach a separate piece of paper, if needed.

_____ Last Name	_____ First Name	_____ School (If Applicable)	_____ Last Name	_____ First Name	_____ School (If Applicable)
_____ Last Name	_____ First Name	_____ School (If Applicable)	_____ Last Name	_____ First Name	_____ School (If Applicable)
_____ Last Name	_____ First Name	_____ School (If Applicable)	_____ Last Name	_____ First Name	_____ School (If Applicable)

Please read each statement and then place your initials to the left of the statement.

I/we certify that the information provided in this document and registration packet is true and no information has been withheld, concealed, or misrepresented for the purpose of circumventing the school attendance laws of the State of Ohio in order to enroll named students in the **Maple Heights City School District**

I/we understand that I/we are responsible for informing school officials of any change(s) in the residence of any parent, legal guardian, or other responsible adult. If I change my present address to another address that is within the **Maple Heights City School District**, I will **immediately** file another residency and custody affidavit with the enrollment office of the **Maple Heights City School District**. I further understand that if the above noted address ceases to be my legal residence and my new residence is outside the boundaries of the **Maple Heights City School District**, I will withdraw my child(ren) from the district and will enroll my child(ren) in the new district of residence.

