DAYTON PUBLIC SCHOOLS

STUDENT ENROLLMENT CENTER
115 South Ludlow Street
Dayton, Ohio 45402-1812
Phone (937) 542-5555 • Fax (937) 542-3202
Hours: Monday-Friday 8:00 a.m. - 4:00 p.m.

WELCOME TO DAYTON PUBLIC SCHOOLS!

To complete the enrollment of your child into Dayton Public Schools, you will need the following:

- Certification of Birth or "proof of age and/or date of birth" **as listed on the back.**
- Immunization (Shot) Records *[Enrollment in Kindergarten requires 5 doses of DTaP, DPT or DT, or any combination (if the fourth dose was administered prior to the 4th birthday), 4 Polio vaccines, 3 Hepatitis B shots, 2 MMR vaccines, and 2 Varicella (Chickenpox)]*
- Proof of Grade Level, such as withdrawal papers, last report card or progress report, certificate of completion, or school documentation verifying student's grade level (transcripts are most helpful for high school students)
- Parent's Valid Photo I.D. with Signature (must not be expired)
- Proof of Address in the parent's name, such as utility bill, lease agreement, mortgage statement, paycheck stub, or other legal documentation (dated within 60 days)
- Custody documentation, *if applicable* (such as divorce decree or court order)
- Child care provider's name, address, and phone number, *if applicable*

PRESCHOOL STUDENTS ONLY

- **Completed shot record** (must have **(4) DPT's or DTaP shots, Polio, (1) MMR, (3) HIB** *three or four doses depending on the vaccine type, the age when the child began the 1st dose*, **(3) Hep B and (1) Varicella** *(Chickenpox)*
- **Physical check-up form for your child** (The State of Ohio requires that we have a physical on file for each student. Please see that your child has a complete physical check-up.)
- **Dental check-up form for your child**
- **Health History**

Please note if you do not have all the documents needed to enroll, you will not be able to enroll the same day.

VISION

To equip our students to achieve success in a global society by implementing an effective and rigorous curriculum with fidelity.

Certification of Birth or "proof of age and/or date of birth"

(a) A passport or attested transcript of a passport filed with a registrar of passports at a point of entry of the United States showing the date and place of birth of the child;

(b) An attested transcript of the certificate of birth;

(c) An attested transcript of the certificate of baptism or other religious record showing the date and place of birth of the child;

(d) An attested transcript of a hospital record showing the date and place of birth of the child;

(e) A birth affidavit.

For Office Use Only

Grade	School	Student ID	Date
Homeroom	Counselor	School Year	Entry Code	Staff Initials

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Dayton, Ohio 45402

NEW STUDENT REGISTRATION

* - Required Field

DAYTON PUBLIC SCHOOLS

Student Information (as on Birth Certificate)

*First Name | Middle Name | *Last Name

Suffix (Jr., II, etc.) | Nickname | *Date of Birth | M F *Gender

*City of Birth | *State of Birth | *Country of Birth

*Home Language | *Native Language | Correspondence Language

*Federal Data Reporting Requirements (Choose only one)

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

*Please continue by checking one or more options to indicate what you consider your student's race to be:

☐ White ☐ Black ☐ Hawaiian or Other Pacific Islander

☐ American Indian/Alaska Native ☐ Asian

*Home Address | Apt

*City | *State | *Zip

*Mailing Address (same as above? ☐ Yes) | Apt

*City | *State | *Zip

*Student Phone Number | *Student Phone Type ☐ Home ☐ Mobile ☐ Work ☐ Pager ☐ Cell-Text Only ☐ Other _

Previous School Information

Last School Attended | Phone | Fax

Address

City | State | Zip

Primary Guardian Information

*Title *(Mr, Ms, etc)* | *First Name | Middle Name | *Last Name | Suffix

*Relationship | *Home Language | *Correspondence Lang | Email Address

*Primary Phone | *Primary Phone Type | Alternate Phone | Alternate Phone Type

Secondary Guardian Information

Title *(Mr, Ms, etc)*	First Name	Middle Name	Last Name	Suffix

Relationship	Home Language	Correspondence Language	Email Address

Primary Phone	Primary Phone Type	Alternate Phone	Alternate Phone Type

Emergency Contact/Pick-up Authorization *(in addition to primary and secondary contacts)*

Emergency Contact?	Name	Relation to Student	Primary Phone & Type	Alternate Phone & Type
☐				
☐				
☐				
☐				

*Permission

☐Yes ☐No	I hereby give my permission to have my child participate in field trips and community experiences (including RTA travel) as a necessary part of the educational process for Dayton Public Schools, as indicated by my signature below.
☐Yes ☐No	I hereby give my permission for my child to be photographed, interviewed, and/or video tape-recorded for news stories, district publications, on the DPS Web/internet, or in other electronic media during his/her enrollment in Dayton Public Schools during the school year, as indicated by my signature below.
☐Yes ☐No	I give permission for my child to be examined by the program's nurse (Exams include: vision, dental, hearing, height, weight, and blood pressure.)
☐Yes ☐No	I give permission for my child to be given educational assessments by the school district personnel on a as needed basis during the school year.
☐Yes ☐No	I give permission to include my name and my child's name and phone number in a class roster to be available upon request by a parent in class. **PRESCHOOL ONLY**

I do not want my child to participate in the following activities:

My signature below certifies the information provided on this Student Registration Form is true to the best of my knowledge. I am also aware that the information I have provided is subject to review and verification and that I may be asked to provide additional documentation to support this form. I understand that it is the responsibility of the student, parent, and/or legal guardian to notify Dayton Public Schools officials immediately upon change of address, custody, or living arrangements. As the parent/guardian of a student enrolled at Dayton Public Schools, I agree to review the district's Student Code of Conduct and understand that my child is responsible for behaving responsibly. The Student Code of Conduct will be provided to your child at his/her assigned school and is available at http://www.dps.k12.oh.us/documents/contentdocuments/doc_23_5_121.pdf

*Signature of Parent or Legal Guardian _____ *Date _____

*Please print name of Parent/Guardian _____ *Date _____

Thank you for choosing Dayton Public Schools.

Please Print

Dayton Public Schools
EMERGENCY MEDICAL AUTHORIZATION

Student's Last Name _____ First _____ Middle _____ Sex _____ Date of Birth _____ Home Phone _____

Student's Address _____ Zip _____

Father/Guardian _____ Employed by _____ Work Phone _____

Mother/Guardian _____ Employed by _____ Work Phone _____

ALTERNATIVE PERSONS TO BE NOTIFIED WHEN PARENTS CANNOT BE REACHED

(1.) _____ Name _____ Phone (2.) _____ Name _____ Phone

COMPLETE PART I, II, AND III. IF REFUSING CONSENT, COMPLETE PART IV.

PART I CONSENT GRANTED

In the event reasonable attempts to contact _____ Parent/Guardian at _____ Phone or _____ Parent/Guardian at _____ Phone have been unsuccessful, I hereby give my consent for: (1). Administration of any treatment deemed necessary by Dr. _____ Preferred Physician Phone (Optional) or Dr. _____ Preferred Dentist Phone (Optional) 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: _____ Preferred Hospital or any hospital reasonably accessible.

THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS/DENTISTS CONCURRING IN THE NECESSITY FOR SUCH SURGERY ARE OBTAINED BEFORE SURGERY IS PERFORMED. PLEASE LIST BELOW FACTS CONCERNING THE CHILD'S MEDICAL HISTORY OR ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED. THE DAYTON PUBLIC SCHOOLS IS WORKING IN COLLABORATION WITH THE CENTER FOR HEALTHY COMMUNITIES TO IMPROVE ACCESS TO HEALTHCARE. TO DO THIS WORK, WE SHARE INFORMATION WITH OTHER LICENSED HEALTHCARE PROVIDERS AND/OR MEDICAID.

Has your child ever had (Please (√) check all that apply):

Heart Trouble_____ Asthma _____ Epilepsy (Seizures)_____ Diabetes (Sugar) _____ Other _____

Explain any allergy or disease causing difficulty: _____

X _____ Signature of Parent/Guardian _____ Address _____ Date

COPY OF OHIO REVISED CODE ON BACK OF THIS FORM

PART II: HEALTH INSURANCE

Do you have health insurance for your child(ren) age 19 and younger?

☐ Yes ☐ No

Insurance Provider_____

PART III: STUDENT'S MEDICATIONS

Does child **regularly** take prescribed medications? ☐ Yes ☐ No

If yes, please list medications:

_____

_____

_____

_____

_____

_____

Are any medications given during school hours?

☐ Yes ☐ No

(If yes, please obtain the Medication Administration form at your child's school.)

PART IV: CONSENT REFUSED

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:* _____

_____

_____

Signature of Parent/Guardian

_____

Address

_____

Date

Revised 12/27/18

DAYTON
PUBLIC SCHOOLS
Revised 10/04/17

Additional Registration Information

Student Name: _____ DOB: _____

1) Is student currently suspended or pending expulsion from last school attended? ☐ Yes ☐ No

   Reason _____

2) Has student ever been expelled from ANY school? ☐ Yes ☐ No District/School _____

3) Child lives with: ☐ Mother ☐ Guardian ☐ Relative ☐ Father ☐ Foster Home

4) Are siblings living in the same home with above student? ☐ Yes ☐ No

5) Is your family temporarily displaced? ☐ Yes ☐ No
   If **yes**, where: ☐ Shelter ☐ Family ☐ Friend / How long? _____

6) Does the student have an Individualized Education Plan (IEP)? ☐ Yes ☐ No

7) Does either parent/guardian work for the military?

   ☐ No
   ☐ **Yes**, Student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marine Corps or Coast Guard).

   ☐ **Yes**, Student is a dependent of a member of the National Guard (Army National Guard or Air National).

Questions Related to Health Services at Time of Registration:

8) Does your child require emergency medication for seizures, such as Diastat or nasal Versed?
   ☐ Yes ☐ No
   If yes, Specify _____

9) Will your child need to receive injections at school? ☐ Yes ☐ No
   If yes, Specify _____

10) Will your child need a nurse for a specific treatment/care? (such as g-tube feeding, catheterization) ☐ Yes ☐ No
    If Yes, Specify _____

11) Does your child have a life-threatening food allergy? ☐ Yes ☐ No
    If yes, Specify _____

Parent Signature: _____ Date: _____

PR-10 PARENTAL CONSENT TO SHARE HEALTH INFORMATION FOR THE OHIO MEDICAID SCHOOL PROGRAM

CHILD'S INFORMATION

CHILD'S NAME _____

DATE OF BIRTH ___/___/___ -DISTRICT NAME _____

Ohio school districts have the opportunity to receive federal Medicaid dollars through a program called the Ohio Medicaid School Program (MSP). Through this program, school districts can receive Medicaid dollars for services identified in the IEP, such as Speech, Audiology, Physical Therapy, Occupational Therapy, Nursing, Psychology, Counseling, and Social Work services. In the process of billing Medicaid for these services, billing information must be shared with the Ohio Department of Medicaid. For Medicaid billing purposes, schools must obtain a one-time signed Parental Consent to Share Health Information For the Ohio School Medicaid Program. After this one-time written consent, you will receive an annual notice of this consent.

Schools request this consent for all students who receive special education services, even students who may not be currently eligible for Medicaid. Some health information shared is specific to your student, while other information is related to all students within the entire school district. Schools can use this health information to help reduce special education costs that the district must deliver pursuant to the Individuals with Disabilities Education Act (IDEA). This student specific health information is protected and will be accessed only by people authorized to do so by the school's Medicaid contract.

Your consent is voluntary. You have the right to withdraw your consent at any time (34 CFR Part 99 and Part 300.) You are not required to enroll in Medicaid. If your school does bill Medicaid, you will not be required to incur any out-of-pocket expenses such as a deductible or co-pay, decreased lifetime coverage, increased premiums or the discontinuation of benefits, or result in you paying for services. If a bill or Explanation of Benefits (EOB) is received, you are not required to cover any cost for school-based services.

Regardless of whether you grant consent, refuse consent, or revoke your consent, your child will still be provided with an evaluation and/or the services as identified by the IEP team at no cost to you.

____ I understand and agree to give permission to share my child's *specific* health information in order for the school to access Medicaid.

____ I do not give permission to share my child's *specific* health information in order for the school to access Medicaid.

Parent (printed) Name _____

Parent Signature _____

Date _____/_____/_____

Please contact **Susan Bollin at 419-346-9651 or susan@weswurd.com** with questions or if you feel you have incurred a personal cost for these services.