



**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)
- 2 Proof of Address in the parent’s name, **Primary Proof of Residency-** Landlord Signed Lease Agreement or Mortgage Statement, or Deed. **Secondary Proof of Residency-** utility bill, 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 1<sup>st</sup> 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.

**VISION**

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

For Office Use Only

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

DAYTON PUBLIC SCHOOLS  
 STUDENT ENROLLMENT  
 CENTER  
 115 S. Ludlow Street  
 Dayton, Ohio 45402

**NEW STUDENT REGISTRATION**  
 \* - Required Field



**Student Information (as on Birth Certificate)**

*First Name	Middle Name	*Last Name	M F
Suffix (Jr., II, etc.)	Nickname	*Date of Birth	*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? <input type="checkbox"/> Yes)	Apt	
*City	*State	*Zip
*Student Phone Number	<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Pager <input type="checkbox"/> Cell-Text Only <input type="checkbox"/> Other	
	*Student Phone Type	

**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 ( <i>Mr, Ms, etc</i> )	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
<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	_____	_____	_____	_____

**\*Permission**

<input type="checkbox"/> Yes <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> 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.)
<input type="checkbox"/> Yes <input type="checkbox"/> 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.
<input type="checkbox"/> Yes <input type="checkbox"/> 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. <b>PRESCHOOL ONLY</b>

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](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.) \_\_\_\_\_ (2.) \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Name \_\_\_\_\_ Phone \_\_\_\_\_

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

### PART I: CONSENT GRANTED

Parent/Guardian \_\_\_\_\_ at \_\_\_\_\_ at \_\_\_\_\_ have been unsuccessful, I hereby give my consent for: (1). Administration of any treatment deemed necessary by Dr. \_\_\_\_\_ or Dr. \_\_\_\_\_ 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 hospital reasonably accessible.

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_ Preferred Physician \_\_\_\_\_ Phone (Optional) \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

**THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS/DENTISTS CONCURRENCE 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 \_\_\_\_\_

SECTION 3313.712, OHIO REVISED CODE  
(Pursuant to Am. H.B. 1175)

**(A)** Annually the board of education of each city, exempted village, local, and joint vocational school district shall, before the first day of October, provide to the parent of every pupil enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into a public school in this state for the first time, provide his parent, either as part of any registration form which is in use in the district, or as a separate form, an identical copy of the form contained in division (B) of this section. When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a city, exempted village, local, or joint vocational school district to which the pupil is transferred. Upon request of his parent, authorities of the school in which the pupil is enrolled may permit the parent to make changes in a previously filed form, or to file a new form.

If a parent does not wish to give such written permission, he shall indicate in the proper place on the form the procedure he wishes school authorities to follow in the event of a medical emergency involving his child.

Even if a parent gives written consent for emergency medical treatment, when a pupil becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extracurricular activity authorized by the appropriate school authorities, the authorities of his school shall make reasonable attempts to contact the parent before treatment is given. The school shall present the pupil's emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section.

**(B)** The emergency medical authorization form provided for in division (A) of this section is as follows: (see reverse side).



## 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 Reserve 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](mailto:susan@weswurd.com) with questions or if you feel you have incurred a personal cost for these services.





PUBLIC SCHOOLS

115 S. Ludlow St. Dayton, OH 45402

Tel. 937-542-3950

Instructions: Complete this survey and return it to your child's school. The following selections must be completed by the Head of Household or Designee: If any member of your household receives Supplemental Nutrition Assistance Program (SNAP) (formerly food stamps) or Ohio Works First (OWF) benefits, provide the name and 7 or 10-digit case number for the person who receives the benefits then proceed to Section 4. If no one receives these benefits, start with Section

1. Name: \_\_\_\_\_ 7 or 10-digit Case Number \_\_\_\_\_

Size of Family: Indicate the total number of individuals living in your household, including all adults and children \_\_\_\_\_

Student Information: Complete for each student (Pre-K through grade 12.

Table with 5 columns: Last Name, First Name, Birthdate, School, and a legend for H-Homeless, F-Foster, M-Migrant Worker, R-Runaway. Rows 1-8.

For additional lines, please attach a second sheet to this survey or attach a copy of this survey marked 4Page 2

TOTAL MONTHLY HOUSEHOLD INCOME- Please indicate income of all members of household excluding foster children. If you have a reported CASE NUMBER, please indicate the number.

Table with 3 columns: Type of Income, Income, and Circle if No Income. Rows 1-6 and Total Monthly Household Income.

Signature - If income section is completed, the adult signing the form must also list the last four (4) digits of this or her Social Security or check the "I do not have a Social Security number box below.

I certify that all information on this application is true and that all income is reported. I understand the school will be eligible for certain federal and/or state funds based on the information I give. I understand that the school officials may verify the information. I understand that if I purposely give false information, my child may lose benefits and I may be prosecuted

Sign here X \_\_\_\_\_ Print Name \_\_\_\_\_

Last Four digits of Social Security Number \_\_\_\_\_ I do not have a Social Security Number

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email address \_\_\_\_\_

Mission Statement

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

This institution is an equal opportunity provider.



Dayton Public Schools is participating in the Community Eligibility Option provision under the National School Lunch Program. Under this option, all children in the school district will receive a breakfast/lunch at no charge, regardless of completion of this form. However, to determine eligibility for various additional state and federal program benefits that your child(ren)'s school may qualify for, please complete, sign, and return this completed application to your student's school building.

**INCOME GUIDELINES- 185%**  
**Guidelines to be effective from July 1, 2019 through July 1, 2020**

Number of persons in family or household	Annual	Monthly	Twice per month	Every two weeks	Weekly
1	\$22,459	\$1,872	\$936	\$864	\$430
2	30,451	2,538	1,269	1,172	586
3	38,443	3,204	1,602	1,479	740
4	46,435	3,870	1,935	1,786	893
5	54,427	4,536	2,268	2,094	1,047
6	62,419	5,202	2,601	2,401	1,201
7	71,411	5,868	2,934	2,709	1,355
8	78,403	6,534	3,267	3,016	1,508
Each additional person add	+7,992	+666	+333	+308	+154

<b><u>For Internal Office Use Only</u></b>	
<b>Qualifies</b>	<b>Does Not Qualify</b>

*Mission Statement*  
*To equip our students to achieve success in a global society by implementing an effective and rigorous curriculum with fidelity.*  
*This institution is an equal opportunity*

## Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

<b>Student Name:</b> <i>(First Name and Last Name)</i> _____		<b>Student Date of Birth:</b> <i>(mm/dd/yyyy)</i> _____	
<b>Communication Preferences</b> Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.		1. In what language(s) would your family prefer to communicate with the school? _____	
<b>Language Background</b> Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.		2. What language did your child learn first? _____ 3. What language does your child use the most at home? _____ 4. What languages are used in your home? _____	
<b>Prior Education</b> Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.		5. In what country was your child born? _____ 6. Has your child ever received formal education outside of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many years/months? _____ If yes, what was the language of instruction? _____ 7. Has your child attended school in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when did your child first attend a school in the United States? _____ / _____ / _____ Month                  Day                  Year	
<b>Additional Information</b> Please share additional information to help us understand your child's language experiences and educational background.			
Parent/Guardian First Name: _____		Parent/Guardian Last Name: _____	
Parent/Guardian Signature: _____		Today's Date: <i>(mm/dd/yyyy)</i> _____	

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: <https://www2.ed.gov/about/offices/list/ocr/ellresources.html>



(Appendix A, continued)

\*\*\*COMPLETED BY SCHOOL EMPLOYEE\*\*\*

1. **Check.** Confirm the following statements related to the administration of Ohio’s language usage survey:
  - The district or school presented the language usage survey, to the extent practicable, in a language and form that the parent or guardian understood.
  - The district or school informed the parent(s) or guardian(s) of the form’s purpose. The language usage survey only is used to understand students’ linguistic experiences and educational background.
  - The district or school reports information from the language usage survey in the appropriate Educational Management Information System (EMIS) records.
  - For students enrolling from other U.S. schools and districts, school officials request previous language survey data and refer to the information when identifying English learners.
  - Results of the language usage survey are kept with the student’s cumulative records and follow the student if he/she transfers to another district or school.

2. **Note.** Record additional information to assist the review of the language usage survey.

3. **Record.** Indicate responses from the language usage survey in the table below. Refer to the [Language Usage Survey Annotations](#) on page 2 for item-specific guidance.

<p><b>Student’s native language</b> See Language Usage Survey Question 2. Report for <u>all</u> students in EMIS.</p>	<p>_____</p>
<p><b>Student’s home language</b> See Language Usage Survey Question 3. Report <u>only</u> for English learners in EMIS.</p>	<p>_____</p>
<p><b>Potential English learner</b> See Language Usage Survey Questions 2-4.</p>	<p><input type="checkbox"/> Yes. Assess the student’s English proficiency. <input type="checkbox"/> No. Do not assess the student’s English proficiency.</p>
<p><b>Immigrant student status</b> See Language Usage Survey Questions 5-7. Report for <u>all</u> students in EMIS.</p>	<p><input type="checkbox"/> Yes, the student is an immigrant child. <input type="checkbox"/> No, the child is not an immigrant child.</p>

4. **Validate.** Complete the information below.

\_\_\_\_\_  
Signature of validating school employee

\_\_\_\_\_  
Date (mm/dd/yyyy)

\_\_\_\_\_  
Printed name of validating school employee

\_\_\_\_\_  
Name of school or school district