



Welcome to FAIRFIELD CITY SCHOOLS

SIGNATURE REQUIRED AT BOTTOM OF PAGE 2
Please complete ALL sections

Office Use Only:

Student ID:

Entry Date ____/____/____

Building _____ AM / PM

HLS IEP Session Change Requested

Transportation Form Attached Intake _____

Preschool Evaluation Only Entry _____

Student Information

Please print. Provide legal names.

Last Name _____ First Name _____ Middle _____

Entering Grade Level _____ Gender (check one): Male Female

Home Address _____ Apartment/Lot/Unit Number _____

City _____ State _____ Zip Code _____

Primary Phone Number _____ (check one): Cell Home

Student Birthplace

City _____ State _____ Country _____

Student Date of Birth ____/____/____ (month/date/year)

Is the student Hispanic or Latino? No Yes

Race/Ethnic Code (check all that apply) Black/African-American White/Caucasian Asian
 American Indian/Alaskan Native Native Hawaiian/Other Pacific Islander

Enrollment Reasons (Check One)

- From Ohio public district or charter/community school
- From home school in Ohio
- From out of state
- From out of country
- From nonpublic school in Ohio

Previous School District attended:

School Name _____ City _____ State _____

First time in Ohio public school due to age

Has this student previously attended Fairfield City Schools?

No Yes (If yes, grade level and year at withdrawal)

Grade _____ School Year _____

If not a Fairfield resident, select reason for enrollment:

- Open Enrollment
- Out of District – Foster placement
- Other _____

Is this student presently under expulsion or suspension? Yes No

For High School Students - school year student began 9th grade _____

Special Services

- Yes No My child has an IEP or is currently receiving Special Service(s).
- Yes No My child is currently on a 504.
- Yes No My child has been identified as gifted or has received gifted services by a previous school district.

Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this survey. 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.

Student Name: <i>(First Name and Last Name)</i>	Student Date of Birth: <i>(mm/dd/yyyy)</i> / /
<p>Communication Preferences 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.</p>	<p>1. In what language(s) would your family prefer to communicate with the school? _____</p>
<p>Language Background 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.</p>	<p>2. What language did your child learn first? _____</p> <p>3. What language does your child use the most at home? _____</p> <p>4. What languages are used in your home? _____</p>
<p>Prior Education 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.</p>	<p>5. In what country was your child born? _____</p> <p>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? _____</p> <p>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</p>
<p>Additional Information Please share additional information to help us understand your child’s language experiences and educational background.</p>	
<p>Parent/Guardian First Name: _____ Parent/Guardian Last Name: _____</p> <p>Parent/Guardian Signature: _____ Today’s Date: <i>(mm/dd/yyyy)</i> _____</p>	

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>



Status of Birth/Adoptive Parents

- Married/Both in Home
 Married/Separated
 Never Married*
 Divorced*
 Mother Deceased
 Father Deceased

**If divorced or never-married father, we require current legal documentation related to the children.*

Contact Information

Student Resides with (Legal Guardian): *(check all that apply)*

- Mother
 Father
 Foster Parent*
 Guardian*
 Grandparent/Power of Attorney*
 Other* _____ **If student is placed with a legal guardian/foster parent or residing with a grandparent, legal documents that identify placement must be provided.*

Contact Information for:

- Mother
 Father
 Guardian
 Caseworker
 Grandparent
 Stepparent
 Foster Parent

Last Name _____
 First Name _____
 Home Phone _____
 Cell Phone _____
 Address same as student

Contact Information for:

- Mother
 Father
 Guardian
 Caseworker
 Grandparent
 Stepparent
 Foster Parent

Last Name _____
 First Name _____
 Home Phone _____
 Cell Phone _____
 Address same as student

Contact Information for:

- Mother
 Father
 Guardian
 Caseworker
 Grandparent
 Stepparent
 Foster Parent

Last Name _____
 First Name _____
 Home Phone _____
 Cell Phone _____
 Address _____
 City _____ State _____
 Zip Code _____

Contact Information for:

- Mother
 Father
 Guardian
 Caseworker
 Grandparent
 Stepparent
 Foster Parent

Last Name _____
 First Name _____
 Home Phone _____
 Cell Phone _____
 Address _____
 City _____ State _____
 Zip Code _____

I, the undersigned, do hereby state and declare under penalty of falsification that I am the parent or legal guardian of the above-named student and that this registration information is true and correct. I understand that any inaccurate information provided may result in a change of grade level, a change of class, or an immediate transfer or withdrawal from this school.*

**Falsification under Ohio Revised Code 2921.13 is a misdemeanor of the first degree punishable by a maximum of (6) months imprisonment and/or a fine of \$1,000.*

Signature _____ Date ____/____/____ (month/date/year)

Statement of Residency

Address _____

City _____ State _____ Zip Code _____

Parent/Guardian

Parent/Guardian Name _____

I affirm that I am the homeowner/leaseholder of the residence listed above, where the above-named student resides:

Yes

No -- Please answer the following questions.

***Homeowner/Leaseholder must complete the box below.**

Is student's current address a temporary living arrangement? Yes No

If yes, is this temporary living arrangement due to loss of housing or economic hardship? Yes No

If yes, where is the student living now?

Motel or Hotel

Homeless Shelter

Doubled up with family or friend

Unaccompanied Youth

Signature _____ Date ____/____/____ (month/date/year)

(Must be signed in the presence of a Fairfield City School District Official)

Please list all persons living in home:

Name Sex Age Relationship to child

Name Sex Age Relationship to child

***Homeowner/Leaseholder (if other than Parent/Guardian)**

Homeowner/Leaseholder Name _____

I affirm that the Parent/Guardian and Student live with me at the residence listed above.

Phone _____

Date Parent/Guardian and student moved to your residence ____/____/____ (month/date/year)

Expected Length of Stay _____ Reason for Co-Residency _____

Signature _____ Date ____/____/____ (month/date/year)

(Must be signed in the presence of a Fairfield City School District Official)

I affirm that all information given above is true and correct. I agree that the Fairfield City School District, if they deem necessary, has the right to investigate my residency. I agree to allow the release of rental information to a representative of Fairfield City School District.

I further understand and agree that the above-named student may be withdrawn immediately from the Fairfield City School District if it is later determined that the parent(s)/guardian(s) are not legal residents of Fairfield City Schools.

A person who knowingly falsifies the above information is committing a misdemeanor of the first degree, punishable by a maximum of (6) months imprisonment and/or a fine of \$1,000. (Ohio Revised Code Section 2921.13)

I have read and understand the above: Parent/Guardian Initials _____ Homeowner Initials _____

FOR OFFICE USE ONLY:

Fairfield City School District Official Signature

Date ____/____/____

FAIRFIELD CITY SCHOOL DISTRICT HEALTH HISTORY FORM

(Both sides of this form to be completed by parent or guardian.)

Child's Full Name _____
Last
First
Middle

Male Female Birthdate _____

Health Conditions: Please check any of the following that your child currently has or has had in the past.

- | | |
|---|---|
| <input type="checkbox"/> Abnormal Spine Curvature (Scoliosis, etc.)
<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Allergies of Hay Fever
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma/Wheezing
<input type="checkbox"/> Behavior Problems
<input type="checkbox"/> Birth/Congenital Malformation
<input type="checkbox"/> Cancer, type _____
<input type="checkbox"/> Chickenpox, date _____
<input type="checkbox"/> Chronic Diarrhea or Constipation
<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Eczema
<input type="checkbox"/> Emotional Disorders
<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Heart Disease, type _____ | <input type="checkbox"/> Hepatitis
<input type="checkbox"/> Kidney Disease, type _____
<input type="checkbox"/> Measles
<input type="checkbox"/> Meningitis or Encephalitis
<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Mumps
<input type="checkbox"/> Nervous twitches/tics
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Seizures or Epilepsy
<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Stool Soiling
<input type="checkbox"/> Substance Abuse (alcohol/drugs)
<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Toothaches/dental problems
<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Urinary Tract Infections
<input type="checkbox"/> Urinary accidents (night/day)
<input type="checkbox"/> Other Chronic Health Problem |
|---|---|

Explain checked items _____

Any condition that would prevent full participation in educational programs (including physical education) requires physician documentation/orders before modifications can be considered. See your School Nurse for further information.

Allergies - Please list and describe allergies/reactions to:

Medication/Drugs _____	Treatment _____
Foods/Plants/Animals/Other _____	Treatment _____
Bee Stings/Insect Bites _____	Treatment _____

If your child requires medication for treatment of an allergic reaction during the school day, see your School Nurse for further information.

Injuries and Illnesses: - Please list any severe injuries or illnesses:

	<u>Date(s)</u>	<u>Hospitalized</u>
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

Vision and Hearing (Check all that apply)

- Frequent Ear Infections (3 or more per year)
 Hearing loss – Circle one: Right / Left / Both
 P.E. Tubes (Date placed _____ Still in place? Yes No
 Last Hearing Exam _____
 Vision Problems
 Wears Glasses Wears Contacts Reason _____
 Last Vision Exam _____

Additional Information:

Does your child see the doctor for a chronic medical condition? Yes No

If yes, please complete the following:

What is the medical condition? _____

Doctor's Name _____ Phone _____

What medications are given daily? _____

What medications are given frequently, but not daily? _____

When did your child last see the doctor for this condition? _____

If your child requires any medication during the school day (prescription or over the counter), see your School Nurse. There are forms that must be completed for medication to be dispensed during school hours.

Doctor's Name _____ Phone _____

Dentist's Name _____ Phone _____

Date of last physical exam _____ Doctor/Clinic (if different from above) _____

Date of last dental exam _____ Dentist/Clinic (if different from above) _____

Immunizations received at _____

This child is usually: Very Active Normally Active Passive

Do you have any concerns about how your child gets along with other children? _____

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly. _____

Has your child ever been evaluated for:

- Speech/Language Impairment
- OT/PT (Occupational or Physical Therapy)
- LD/SLD (Learning Disability/Specific Learning Disability)
- CD (Cognitive Disability)
- MD (Multiple Disabilities)
- ED (Emotional Disabilities)

Other household members:

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Form completed by _____

Relationship to child _____

I (do/do not) give my permission for the School Nurse to share this confidential information as needed for the benefit of my child's health and educational needs, except for the following conditions: _____

Signature

Date

Phone

Fairfield City School District

School Record Request

IRN: 046102

Student Information:

Student Name: _____ Grade: _____ Birthdate: _____

Parent/Guardian Signature: _____ Date: _____

Please print parent/guardian name clearly: _____

Name and address of school releasing records:

Phone number of school releasing records:

Phone: _____

Fax: _____

TO BE COMPLETED BY PREVIOUS OHIO SCHOOL DISTRICT

School District _____ School Name _____

District IRN # _____ Last day the student attended your district _____

Please release all appropriate past and present academic, discipline, medical, confidential and special education records (including psychological information, diagnostic summaries, IEP, etc.) on the student named above.

Records should be sent to the school address indicated below.

Release Records To:

Fairfield Central Elementary
5054 Dixie Hwy.
Fairfield, OH 45014
Phone: 513-829-7979
Fax: 513-829-7830

Fairfield Compass Elementary
8801 Holden Blvd.
Fairfield, OH 45014
Phone: 513-858-8700
Fax: 513-858-8699

Fairfield East Elementary
6711 Morris Rd.
Hamilton, OH 45011
Phone: 513-737-5000
Fax: 513-737-5225

Fairfield North Elementary
6116 Morris Rd.
Hamilton, OH 45011
Phone: 513-868-0070
Fax: 513-868-3621

Fairfield South Elementary
5460 Bibury Rd.
Fairfield, OH 45014
Phone: 513-829-3078
Fax: 513-829-8350

Fairfield West Elementary
4700 River Rd.
Fairfield, OH 45014
Phone: 513-868-3021
Fax: 513-868-3624

Fairfield Creekside Middle
1111 Nilles Rd.
Fairfield, OH 45014
Phone: 513-829-4433
Fax: 513-829-6480

Fairfield Crossroads Middle
255 Donald Dr.
Fairfield, OH 45014
Phone: 513-829-4504
Fax: 513-829-7447

Fairfield Freshman School
8790 N. Gilmore Rd.
Fairfield, OH 45014
Phone: 513-829-8300
Fax: 513-829-4733

Fairfield High School
8800 Holden Blvd.
Fairfield, OH 45014
Phone: 513-942-2999
Fax: 513-942-3288