

TWO DIMENSIONS PREPARATORY ACADEMY CHARTER SCHOOL

Veterans Memorial Campus
 12121 Veterans Memorial Dr. # 7
 Houston, TX 77067
 281-227-4700/ phone
 832-232-0032/ fax

Corsicana Campus
 901 East 10th Street
 Corsicana, TX 75110
 281-227-4700/ phone
 903-872-2858/ fax

Vickery Campus
 12330 Vickery
 Houston, TX 77039
 281-227-4700/ phone
 281-987-7306/ fax

RETURNING STUDENT - ENROLLMENT FORM 2019– 2020

*****Blue Ink Only*****

Child's Name as it appears on the birth certificate:

Last _____ First _____ Middle _____

Grade applying for: _____

Date of Birth: _____ Child's social security number: _____

Age by September 1, 2019: _____ Is your child a legal citizen Yes No

What school district do you reside? _____

Ethnicity- Is the student Hispanic or Latino? Yes No

Check All That Apply: African American/ Black Asian Pacific Islander Hispanic/Latino
 Native American/Alaskan Native White

Child's Gender: Male Female

With whom does the child reside? _____ Relationship: _____

Mother's name: _____ Home phone: ____/____/____

Address _____ Apt. # _____ City/State/ Zip _____

Employer: _____ Work #: ____/____/____ Cell #: ____/____/____

Email address: _____ @ _____

Father's name: _____ Home phone: ____/____/____

Address _____ Apt. # _____ City/State/ Zip _____

Employer: _____ Work #: ____/____/____ Cell #: ____/____/____

Email address: _____ @ _____

Legal guardian's name: _____ Home phone: ____/____/____

Address _____ Apt. # _____ City/State/ Zip _____

Employer: _____ Work #: ____/____/____ Cell #: ____/____/____

For School Use Only

<p><input type="checkbox"/> Date received in office: _____</p> <p><input type="checkbox"/> Guardianship or Custody verified TDL/ID # _____</p> <p><input type="checkbox"/> Proof of Residency Date: _____</p> <p><input type="checkbox"/> Corporal Punishment: _____ Yes _____ No</p> <p><input type="checkbox"/> Residential District Reside In: _____</p> <p><input type="checkbox"/> Lunch Application Date: _____ Complete: _____ Yes _____ No</p> <p><input type="checkbox"/> Immunizations: _____ Complete _____ In Process _____ Waiver _____ Not Provided</p> <p>Enrollment Date: _____ Grade: _____</p>	<p style="text-align: center;">Homeless Status Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: center;">Home Language Survey Spoken in home most of time <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____</p> <p>Child speak most of time <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____</p> <p style="text-align: center;">_____ Date sent to PEIMS Coordinator</p> <p>_____ Administrator Signature</p> <p style="text-align: right;">_____ Date</p>
---	---

I authorize the release of my child to the following: (in addition to those listed below)

Name	Relation to the student	Phone Number

In case of an emergency (illness or accident) Two Dimensions is authorized to act as directed below. Please list two contact persons when a parent cannot be reached.

Emergency Contact	Address	Phone Number
1.		
2.		
Contact Family Physician:		
Daycare Provider:		

Other Children in the family:

Last Name	First Name	Date of Birth	School Attending

List any health concerns for your child: _____

Is your child currently taking any prescription medications? Yes No

Please list: _____

Are there any custody issues that the school needs to be aware of?

Yes No If yes, please provide legal documents.

Parent Signature: _____ Date: _____

Registrar Signature: _____ Date: _____

TWO DIMENSIONS PREPARATORY ACADEMY CHARTER SCHOOL

Daisy Simpson, Superintendent ♦

Administrative Office:

12121 Veterans Memorial #7 • Houston, TX 77067 • 281-227-4700/fax 832-232-0032

Corporal Punishment

Yes, I the Parent of _____, give **Two Dimensions** permission to administer corporal punishment to my child whenever the administrator deems it necessary. I understand that the school may or may not call me prior to this action.

No, I the Parent of _____, do not give **Two Dimensions** permission to administer corporal punishment to my child. **I understand that I am required to contact the campus to make adjustments for my child's behavior.**

Father/ Guardian: _____ Date: _____

Mother/Guardian: _____ Date: _____

Castigo Corporal

Sí, padre de I del permiso de las Dimensiones de la elasticidad dos del _____, De administrar el castigo corporal a mi niño siempre que el administrador lo juzgue necesario. Entiendo que la escuela puede o no puede llamarme antes de esta acción.

No, padre de I del permiso de las Dimensiones de la elasticidad dos del _____, do no de administrar el castigo corporal a mi niño. **Entiendo que me requieren en contacto con el campus para hacer los ajustes para el comportamiento de mi niño.**

Padre /Guarda del: _____ Fecha del: _____

Madre/Guarda del: _____ Fecha del: _____

TWO DIMENSIONS PREPARATORY ACADEMY CHARTER SCHOOL

Veterans Memorial Campus
12121 Veterans Memorial Dr. # 7
Houston, TX 77067
281-227-4700/ phone
832-232-0032/ fax

Corsicana Campus
901 East 10th Street
Corsicana, TX 75110
281-227-4700/ phone
903-872-2858/ fax

Vickery Campus
12330 Vickery
Houston, TX 77039
281-227-4700/ phone
281-987-7306/ fax

TDPACS Policy Awareness

I, _____, have been made aware by Two Dimensions Charter School staff that I must read and adhere to the following policies:

- Promotion Standards
- Acceptable Use and Internet Policy
- Pick/Up Drop-off Policy
- Attendance Policy
- Tardy Policy
- Official Uniform Policy
- Parent Involvement Policy & School-Parent Compact

These policies can be found on the school's website at www.twodimensions.org in the Two Dimensions Preparatory Academy Charter School Parent/Student handbook. These documents can also be requested from the campus Registrar.

Parent Signature

Date

Student Name

MIGRANT EDUCATION PROGRAM



District Name: _____ Date: _____
School Name: _____

Dear Parents,

In order to better serve your children, the school district would like to identify families and out-of-school youth who are agricultural or fishing workers and who may qualify to receive additional educational services. The information provided will be kept confidential. Please answer the following questions and return this survey form to your child's school.

1. Have you done seasonal or temporary agricultural or fishing-related work (e.g., field work, canneries, lumbering, dairy work, or meat processing) during the last 3 years?
Yes _____ No _____
2. Have you moved between school districts and/or states during the last 3 years due to economic necessity?
Yes _____ No _____
3. Do you have a child under the age of 22 who lacks a U.S. -issued high school diploma or Certificate of High School Equivalency (HSE/GED) and is currently not enrolled in school?
Yes _____ No _____

The Migrant Education Program offers a variety of supplemental academic and support services to all identified migrant children and out-of-school youth who move with their families to harvest the fruits and vegetables that help feed our nation. Services are provided by school districts and the community and vary by district regardless of immigration status.

Make sure you complete and return this survey to your child's school. An education representative may contact you to provide additional information and see if your child is eligible for the Migrant Education Program. Please provide the following information:

Name of the Child _____ D.O.B. _____ Age _____ Grade _____
Parent or Guardian Name _____
Telephone Number _____
Best time to contact you _____
If you would like more information, call _____.





ENCUESTA DEL

PROGRAMA DE EDUCACIÓN MIGRANTE

Distrito escolar _____ Fecha: _____
Escuela: _____

Estimados padres,

Para mejorar los servicios educativos de sus hijos, el distrito escolar quisiera identificar a familias y jóvenes fuera de la escuela que trabajan en agricultura o pesca y que pueden calificar para recibir servicios educativos adicionales. Toda la información proporcionada se mantendrá de forma confidencial. Favor de responder a las siguientes preguntas y devolver esta forma a la escuela de su hijo(a)

4. ¿Ha trabajado usted o su familia por temporadas en la agricultura o en la pesca (por ejemplo, la labor, fábrica de conservas, explotación de bosques, trabajo en una lechería, el proceso de carne) en los últimos 3 años?

Si _____ No _____

5. ¿Se ha mudado de un distrito escolar y/o estado a otro por razones económicas durante los últimos 3 años?

Si _____ No _____

6. ¿Tiene un hijo(a) menor de 22 años de edad, que no se ha graduado de la preparatoria en los Estados Unidos o ha obtenido un certificado equivalente de preparatoria (HSE/GED) y no está inscrito en la escuela?

Si _____ No _____

El Programa de Educación Migrante ofrece una variedad de servicios suplementarios académicos y de apoyo a todos los niños y jóvenes migrantes identificados que viajan con sus familias para cultivar las frutas y vegetales que ayudan a alimentar a nuestra nación. Dichos servicios son ofrecidos a través de los distritos escolares y de la comunidad y varían según el distrito escolar sin importar el estatus migratorio de las familias.

Por favor complete y devuelva esta encuesta a la escuela de su hijo(a). Un representante del distrito escolar podría comunicarse con usted para determinar si su niño(a) califica para el Programa de Educación Migrante. Favor de completar la siguiente información:

Nombre del Estudiante _____ Fecha de Nacimiento _____ Edad ____ Grado _____

Nombre del Padre o Guardián _____

Número de Teléfono _____

La Mejor Hora para localizarlo _____

Si desea obtener más información, llame a _____



Student Services Questionnaire

Student Name: _____

Grade: _____

Answering the questions below will help Two Dimensions identify what additional services your child will benefit from.

<input type="checkbox"/> Yes <input type="checkbox"/> NO	Is English the primary language spoken in the home? If no, what language is spoken in the home? _____
<input type="checkbox"/> Yes <input type="checkbox"/> NO	Does the student and parents of the student temporarily reside with another individual who is responsible for rent, mortgage and other household utilities?
<input type="checkbox"/> Yes <input type="checkbox"/> NO	Does the student and parents of the student currently reside in a hotel or motel?
<input type="checkbox"/> Yes <input type="checkbox"/> NO	Does the student reside, or has resided in the previous school year in a residential placement facility, substance abuse treatment facility, emergency shelter, psychiatric hospital, halfway house, or foster group home?
<input type="checkbox"/> Yes <input type="checkbox"/> NO	Has the student repeated one or more grade level? If yes, what grade level and school year? _____
<input type="checkbox"/> Yes <input type="checkbox"/> NO	Has the student performed poorly on an assessment instrument (state tests, STAAR, local benchmark, TPRI, etc.) in the current and previous school year?
<input type="checkbox"/> Yes <input type="checkbox"/> NO	Is the student in Pre-Kinder, Kindergarten, or grade 1, 2, or 3, and did not perform satisfactorily on a readiness test or assessment instrument administered during the current school year?
<input type="checkbox"/> Yes <input type="checkbox"/> NO	Has the Student been placed in an alternative education program during the previous or current school year?
<input type="checkbox"/> Yes <input type="checkbox"/> NO	Has the student been expelled during the previous or current school year?
<input type="checkbox"/> Yes <input type="checkbox"/> NO	Has the student received Special Services during the previous or current school year? (Speech Therapy, Gifted and Talented, or Special Needs)?

Receiving Staff Signature:

Date Sent to PEIMS:

**Two Dimensions Preparatory Academy Charter School
Emergency Medical Treatment Form**

In the event of a medical emergency at any Two Dimensions Preparatory Academy Charter School campuses, the school will first try to contact the child's parents. If the parent cannot be reached, and the child needs immediate medical treatment, the form below would be given to the hospital or clinic. The purpose of the Emergency Medical Treatment Form is to obtain medical treatment for your child in the event you cannot be contacted.

Please complete form below and sign

I hereby authorize the staff at Two Dimensions Preparatory Academy Charter School _____ Campus to consent to emergency medical treatment for:

Student's First/Middle/Last Name _____
Birth Date _____ Grade _____ Parent Name _____
Home Phone# (include area code) _____ Cell Phone # (include area code) _____
Work Phone # (include area code) _____ Other # _____

I understand in granting this authorization that:

- My child will be taken to a hospital or clinic located nearest to the school or activity he/she is attending so that emergency medical treatment can be obtained.
- School staff will attempt to contact me before consenting to emergency medical treatment for my child.
- I will be responsible for all expenses incurred by desirable quality of the emergency medical treatment of my child and for the transportation to the emergency medical treatment facility.
- I release Two Dimensions Preparatory Academy Charter School staff members and Board of Directors from any and all claims or actions from liabilities for the injuries that occur to my child as a result of his/her receipt of emergency medical care.
- The staff of Two Dimensions Preparatory Academy Charter School, its Board of Directors and agents is not waiving any sovereign or governmental immunity by requesting the execution of this document.
- I understand the provisions of this document and execute it voluntarily.

Print Name of Parent or Guardian

Important Medical Information (PLEASE FILL OUT INFORMATION BELOW)

List any medical problems your child has which medical personnel need to be aware of in an emergency:
Diabetes Asthma Seizures Heart problems ADD/ADHD Headaches
Hearing Loss Nose Bleeds Seizures/Epilepsy Other (Specify) _____
Explain any checked boxes: _____

Glasses/Contact Lens Yes No Last Eye Exam: _____

List medication(s), dosage and frequency your child takes daily (either at home or school)
_____ Dose: _____ Frequency _____
_____ Dose: _____ Frequency _____

List allergies (Food allergens required a doctor statement for food/drink substitutions)
To foods No Yes Please List: _____
To drugs No Yes Please List: _____
To insects No Yes Please List: _____
List any other items(s) not mention above: _____
If yes, what treatment is given? _____

Family physician: _____ Phone # ____/____/____
Health insurance company name: _____ Phone # ____/____/____