Akron Public Schools

☐ Enrollment/Re-enrollment
☒ Information Update Only

Akron Public Schools

Opening School Information Form

Office Use Only
Student ID _____
Primary Homeroom_____
Effective Start Date ___/___/___

0. Office Use Only		
eSchoolPlus Data Entry	**Required Student Documentation**	**Funding and State Reporting Information**
☐ Registration ☐ Emergency	☐ Proof of Custody ☐ Proof of Residency	IRN _____ OVER _____ ☐ Records Rq
☐ Birth Parents ☐ Immunizations	☐ Birth Certificate ☐ Proof of Immunizations	RESC _____ CRD _____ ☐ Tuition

OS1. Student Demographics						
a. Full Legal Name						
Full name must appear EXACTLY as indicated on birth certificate, legal change of name document, or other appropriate documentation. You must include punctuation, misspellings and generation (ex. Jr). Nicknames, shortened names, or preferred names are not permitted.						
b. Sex	☐ Male ☐ Female	c. Birth Date	___/___/___	d. Student SSN (optional)	___-___-___	e. Grade
f. Ethnicity	☐ YES, my child is of Hispanic/Latino ethnicity ☐ NO, my child is **NOT** of Hispanic/Latino ethnicity			g. Race (check all that apply)	☐ White ☐ Asian ☐ Black or African-American ☐ Pacific Islander ☐ Amer. Indian/Native Alaskan	
h. Home Language	*What language is primarily spoken at student's home?*			i. Native Language	*What language was first spoken at the onset of speech?*	
j. Birth City		k. Birth State/ Province *US/CA*		l. Birth Country		

OS2. Student Contact Information								
a. Home Address		b. Apt		c. City		d. State		e. ZIP
☐ ***Check this box if you DO NOT want student information mailed to the above address. If checked, continue to (f), otherwise skip next line to (k).***								
f. Mailing Address		g. Apt		h. City		i. State		j. ZIP
k. First Phone to Contact	(___) ___-____	l. All-Call Phone*	(___) ___-____	m. Student Email				
*** All-Call is Akron Public Schools' system that will automatically call you to notify of school information (closings, events, absences, etc.)**								

OS3. Primary Adult Living With Student					
a. Last Name		b. First Name		c. Guardian	☐ YES, this person is a legal guardian ☐ NO, this person is **NOT** a legal guardian
d. Relationship	☐ Birth Mother ☐ Grandmother ☐ Other (please specify below) ☐ Birth Father ☐ Grandfather _____			e. Email Address	
f. Home Phone	(___) ___-____	g. Cell Phone	(___) ___-____	h. Work Phone	(___) ___-____ x

OS4. Secondary Adult Living With Student					
a. Last Name		b. First Name		c. Guardian	☐ YES, this person is a legal guardian ☐ NO, this person is **NOT** a legal guardian
d. Relationship	☐ Birth Mother ☐ Grandmother ☐ Other (please specify below) ☐ Birth Father ☐ Grandfather _____			e. Email Address	
f. Home Phone	(___) ___-____	g. Cell Phone	(___) ___-____	h. Work Phone	(___) ___-____ x

OS5. Emergency Medical Contact Information					
Please list below up to three (3) additional people that may be contacted in the event of a medical emergency and the guardians listed on the previous page are not available. DO NOT RE-LIST the adults from the previous section. NOTE: the school cannot contact these emergency medical contacts unless there is a medical emergency. They may not sign out a student without consent from a guardian at the time of sign out.					
a. Contact 1 Name				b. Contact 1 Relationship	
b. Home Phone	(___) ___-____	c. Cell Phone	(___) ___-____	d. Work Phone	(___) ___-____ x
e. Contact 2 Name				f. Contact 2 Relationship	
g. Home Phone	(___) ___-____	h. Cell Phone	(___) ___-____	i. Work Phone	(___) ___-____ x
j. Contact 3 Name				k. Contact 3 Relationship	
l. Home Phone	(___) ___-____	m. Cell Phone	(___) ___-____	n. Work Phone	(___) ___-____ x

(continue to next page – turn over to the other side)

OS6. Health Provider Information							
a. Physician		b. Phone		c. Dentist		d. Phone	
e. Mental Health Spec.		f. Phone		g. Preferred Hospital			

OS7. Allergies and Other Medical Conditions (Check all that Apply)			
☐ Allergy – Emergency (Epipen)	☐ Bleeding / Blood Disorder	☐ Immunocompromized / Malignancies	☐ Seizures / Neurologic
☐ Allergy – Food	☐ Cardiovascular / Hypertension	☐ Other Condition Not Covered Here	☐ Vision Problems
☐ Allergy – General	☐ Diabetes	☐ Sickle Cell Disease	
☐ Asthma / Respiratory	☐ Hearing Problems	☐ Special Medical Procedure	

a. Detailed Information	*Please indicate the nature of the condition(s) selected above in this box*

If your child has been determined by a doctor to have a disability or food allergy requiring substitutions to school meals, a note from a doctor must be provided indicating the medical condition and food(s) to be avoided or substituted. For questions, please contact the Office of Child Nutrition at (330) 761-1335.

b. Current Medications		c. Additional Medical Info	

OS8. Emergency Situations	
a. Emergency Dismissal	*In the event of an emergency dismissal (the closure of school before the regular dismissal time), my child* ☐ Can walk or be sent home on the bus ☐ Will be picked up as soon as possible ☐ Must remain until regular dismissal time
b. Emergency Treatment	*Please indicate below whether the school authorities are permitted to provide treatment for your child should (s)he become ill, injured, or in need in of mental health emergency services while under school authority. If consent is given below, in the event reasonable attempts to contact me or other parents (at the above numbers) have been unsuccessful, the student shall [1]be administered any treatment deemed necessary by preferred physician, preferred dentist, or preferred mental health specialist (indicated above), or in the event the designated preferred practitioner is not available, by another licensed physician, dentist, or mental health specialist, and [2] the transfer of the child to the preferred hospital or emergency care facility of any hospital reasonably accessible.* *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 such surgery is performed.* ☐ **I DO** give my consent for emergency medical, dental, or mental health treatment of my child. ☐ **I DO <u>NOT</u>** give my consent for emergency medical, dental, or mental health treatment of my child. I wish school authorities to take no action or to _____

OS9. Signature of Parent / Guardian		
x _____	Date	___/___/___