ANNEX SITE

2015/2016ENROLLMENT/INFORMATION FORM

Please Print-Make sure that all information is filled out completely, accurately and legibly. Your child's enrollment will not be processed until all documents in enrollment packet are complete.

Student Name_____
(Last) (First) (Middle)
2015/2016- Grade Level _____ Male_____ Female_____ Date of Birth _____

Address _____

City _____ Zip _____

Parent/Guardian Primary Caregiver(s) Name(s): _____

Adult #1:
Full Name _____
❑ Parent
❑ Stepparent Address _____
❑ Guardian
❑ Grandparent Home Phone_____ Cell phone_____
❑ Other Occupation _____ Employer _____
E-mail address_____ Other phone_____
Check if mailings should be sent to this address Check if adult lives with child

Adult #2:
Full Name _____
❑ Parent
❑ Stepparent Address _____
❑ Guardian
❑ Grandparent Home Phone_____ Cell phone_____
❑ Other Occupation _____ Employer _____
E-mail address_____ Other phone_____
Check Check if mailings should be sent to this address Check if adult lives with child

Adult #3:
Full Name _____
❑ Parent
❑ Stepparent Address _____
❑ Guardian
❑ Grandparent Home Phone_____ Cell phone_____
❑ Other Occupation _____ Employer _____
E-mail address_____ Other phone_____
Check Check if mailings should be sent to this address Check if adult lives with child

I give permission to use student's name, primary caregiver's name, address, telephone number and email address provided for distribution in the iLEAD student directory. The iLEAD Directory will only be distributed to enrolled iLEAD families.

Parent/Guardian Signature _____ **Date** _____

After School Care: ❑ Student has arrangements.
Please indicate location _____.
Sibling(s) at iLEAD:
1. _____ Grade _____
2. _____ Grade _____
3. _____ Grade _____
4. _____ Grade _____

Are there any Custody, Visitation, or other orders limiting access to this child? _____If yes, please specify orders: _____

_____

It is the parent/guardian's responsibility to provide iLEAD with a copy of any Restraining Order or Custodial Parent Visitation Orders and any subsequent updates.

#1_____ _____ _____
Local Contact Person Name **Relationship** **Occupation**

Phone# _____**Phone Type (please check one)**:_____**Cell** _____**Home** _____**Work**

#2_____ _____ _____
Local Contact Person Name **Relationship** **Occupation**

Phone# _____**Phone Type (please check one)**:_____**Cell** _____**Home** _____**Work**

#3_____ _____ _____
Local Contact Person Name **Relationship** **Occupation**

Phone# _____**Phone Type (please check one)**:_____**Cell** _____**Home** _____**Work**

BACK-UP EMERGENCY INFORMATION

Emergency Contacts: **IN CLOSE PROXIMITY TO THE SCHOOL** will be called, if parent/guardian cannot be reached.

In case of emergency: May the school secure paramedic assistance to transport your child to the hospital?
Yes
❑ No Please explain: _____
_____

Medical Alert Information:

_____

_____

Does the student have vision or eye problems? ❑ (yes), ❑ (no)
If yes, wears glasses or contacts:
❑ For board work
❑ For reading
❑ All the time
Does the student require special seating needs in the classroom due to hearing, vision or medical needs?

_____

Allergies: Please list any known allergies and/or reaction(s) the student has.
Food/Other Allergies: _____
Reaction(s): _____
Medication: _____ Epi Pen: _____
Will medication be administered by school staff? _____
Will medication be stored at school? _____ **(if so, an authorization to administer medication at school must be completed by the prescribing physician and turned into the health office along with the medication)** No medication, prescription or non-prescription, are to be sent to school with the child (exceptions are made if physician states that the student must carry said medication at all times).

Special Education:
Does the student have an active IEP? _____ If yes, please attached a copy of the IEP with your application.
Please identify which school district developed the IEP. _____
❑ Hard of Hearing
❑ Deaf
❑ Specific learning disability, please name:_____
❑ Orthopedic impairment
❑ Speech/Language Impairment
❑ Multiple Disability, please specify which ones: _____
❑ Autism
❑ Other:_____

Does the student have an active 504 plan? _____ If yes, please attached a copy of the 504 plan with your application.

Authorization for iLEAD to seek Emergency Medical Treatment:

In the case of an emergency, (I) (WE), the undersigned parent(s)/guardian(s) of: _____ minor do hereby authorize iLEAD as agent for the undersigned to consent to any x-ray treatment, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent to give specific consent. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until _____, unless sooner revoked in writing to said agent.

_____	_____	_____
Date	**Parent/Guardian Signature**	**Parent/ Guardian Signature**