Today's Date:_____

NEW Student Registration

Complete both sides of the forms. Please answer all questions that apply.

OFFICE USE ONLY		
Previous School	**Student #**	Student Entry Date
Grade Level	Teacher	Birth Certificate Yes No
Immunization Certification Full Temp Exempt		Physical Yes No
Transportation: Walker Car Ext. Day SN Sibling(s)		

Student Legal Name (first, middle, last)	Suffix (Jr., Sr., II, III, IV, V)	**Student** Date of Birth (mm/dd/yyyy)

Grade Level This School Year	Grade Level Last School Year	**Student** Soc. Sec. # (requested) *	**Student** City and State of Birth

Has the student attended public school in Fulton County before?

Yes __ No __

Student Country of Birth

USA ____ Other:_____

Student Ethnic Origin (Must check Yes or No)

Yes, Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, Latino South Central American, or other Spanish culture or origin, regardless of race)

No, not Hispanic or

Student Race (check all that apply)

American Indian or Alaskan Native - I (origins in any of the original peoples of North or South America [including Central America] and who maintains tribal affiliation or community attachment)

Asian - A (origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, (e.g., Cambodia**,** China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam)

Black or African American - B (origins in any of the black racial groups of Africa)

Native Hawaiian or Other Pacific Islander - P (origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

White - W (origins in any of the original peoples of Europe, Middle East, or North Africa)

Student Gender

M F

Student Home Phone #

Student Address

House number and street name, apartment #, city, state, zip code, Housing Development Name (if applicable)

Residence County (if other than Fulton County): _____

Check all that apply to the student's current residence:

Shelter	Hotel/Motel	Shelter/Group Home
Shared Housing Due to Hardship Space Not Designed for Human Habitation	Awaiting Foster Care Foster Parent	Relative Care Independent Living Does not apply

What date did the student first enroll in a K-12 US school? (MM/DD/YYYY)

	If yes, what language?	
1. Is a language other than English used in the home?	Yes _____	No
2. Did the student have a first language other than English?		No
3. Does the student most frequently speak a language other than English?	Yes _____	No
	Yes _____	

Ahayah Academy New Student Registration **Student Name: _____**

For Students Entering Kindergarten only - Preschool Enrollment Information - (circle all program(s) attended)

Pre-K Disabilities	Head Start	Private Provider VPK
Parent Paid	Did not Attend Preschool	Private Provider VPK
Pre-K	School District Pre-K	

If student attended Pre-K, **name of Pre-K provider**:_____

Entry Disclosures (check all that apply)

The student has been expelled from school. Name of school_____

The student has been arrested or prosecuted for a violation of a criminal statute resulting in a charge. Yes No

The student has been involved with the juvenile justice system. Yes No

PARENT/GUARDIAN INFORMATION (Please list Parent/Guardian information in order of contact priority)

PARENT OR GUARDIAN			
	First and Last Name		Relationship to student: Mother Father Foster Parent Stepmother Stepfather Legal Guardian
	Home Telephone	Cell Phone	Work Telephone
	Address if not the same as student (house #, street name, apartment no., city, state, zip code)		
	E-mail address		

PARENT OR GUARDIAN			
	First and Last Name		Relationship to student: Mother Father Foster Parent Stepmother Stepfather Legal Guardian
	Home Telephone	Cell Phone	Work Telephone
	Address if not the same as student (house #, street name, apartment no., city, state, zip code)		
	E-mail address		

Student Residence Information Indicate with whom the student lives (check only one):

Both Parents Mother Father Parent and Step-Parent Legal Guardian

Other: _____

Not in physical custody of Parent/Guardian (**Unaccompanied Youth**) Yes ___ No ___

Are you a parenting teen? **Yes** ___ **No** ___

If yes, provide the following:_____ _____

Child's name Date of birth

Ahayah Academy New Student Registration **Student Name: _____**

STUDENT EDUCATION INFORMATION

Name of Last School Attended	Telephone - Last School Attended	School Type (circle one only) public *(charter schools included)* ___ private ___ Pre-K ___ home education ___
City of Last School Attended		State of Last School Attended
County of Last School Attended		Country of Last School Attended: USA ____ Other: _____

Educational Plan: check any that apply. Provide a copy of the plan with this registration.

Individual Education Plan *(IEP)*_____504 Plan _____Private School Services Plan ____Education Plan (Gifted only____

IMPORTANT: EVERYONE MUST ANSWER QUESTIONS A-D BELOW

A. Is there Court Order **barring either parent from removing the student** from school? If yes, **provide school with a copy** of the most current Court Order.	**Yes**	**No**	**N/A**
If divorced or separated:			
B. Do parents have **shared (or joint) parental rights and responsibilities**? If no, **provide the school** with a copy of the Court Order which limits either parent's parental rights or responsibilities regarding the student.	**Yes**	**No**	**N/A**
C. Does either parent have **final decision-making authority regarding educational decisions** for the student? If yes, **provide the school with a copy** of the Court Order stating that one parent has final parental decision-making authority regarding education.	**Yes**	**No**	**N/A**
D. Is there a **Temporary Restraining Order, Permanent Restraining Order, Order of No Contact, or other Court Order** that restricts or impacts access to the student by anyone, including a parent? If yes, **provide school with a copy** of the most current Court Order.	**Yes**	**No**	**N/A**

Read the following carefully. Check appropriate box below statement and sign below.

Student Media Release: I hereby authorize the videotaping/filming/photography of my child, and/or the release of his/her name and achievement(s) for publishing (print, World Wide Web) and/or broadcasting purposes. I also consent to the showing of video/film/photographs to any person. I understand that the Ahayah Academy Education System is not a party to outside organizations' photography/filming/video production and will hold Ahayah Academy Education System and its employees harmless from any liability in connection with a production not produced internally by Ahayah Academy Education System.

I give permission _____ I do not give permission _____

Notice of Technology Acceptable Use Policy For Students: Your child may have access to many school-related activities and technology resources, including the internet. Internet access at your child's school is filtered, monitored and is compliant with the Child Internet Protection Act (CIPA) and school Internet Usage Policy. Your child will be required to follow the Acceptable Use Policy and guidelines that are stated in the Policy, the referenced Manual, and be bound to those terms. There is NO expectation of privacy while utilizing the Ahayah's network, computers, or any device attached to the network. Before your child uses these resources, he/she will read, be read to, and/or have the documents explained to him/her.

Initial to confirm understanding _____

Would you like to receive **text messages***, auto-dialed and/or pre-recorded calls and text messages from the school, regarding school closings or upcoming events?

Yes_____ Number to be texted _____
No _____

**Text message charges may apply, depending on your cell phone plan. Please check with your cell phone provider.*

REGISTRATION IS NOT VALID WITHOUT SIGNATURE AND DATE.

Under penalty of perjury, I declare that I have read the foregoing form and that the facts stated in it are true and accurate.

_____

Parent/Guardian/Surrogate Signature (Student Signature if emancipated)

_____

Date

DOCTOR **/** PRIMARY HEALTH CARE PROVIDER: Name:_____Phone:_____

I hereby give consent for my child to participate in the School Health Service Program and to receive nursing and emergency care at the school, if needed. Screening and evaluation for problems in the areas of vision, hearing, growth and development, nutrition, dental, scoliosis, communicable diseases, blood pressure, speech and language, or other non-invasive health screenings may be done as part of the program.

In the event of a serious accident or illness, I request that the school contact me. If I cannot be reached, I request designated school personnel to take or send my child to the hospital determined by Emergency Services personnel. I consent to be responsible for all expenses incurred. In case of an accident or illness where immediate medical treatment is not indicated, but where my child is unable to remain in school, I request the school contact me. If I cannot be reached, I request that one of the persons listed as approved to pick up my child be contacted to remove my child from school and to be responsible for his/her care. These persons have transportation and are immediately available to come to school.

PRINT *Parent/Guardian/Surrogate Name*_____

Parent/Guardian/_____***Signature Date:*** __

This page intentionally left blank.

Ahayah Academy New Student Registration	Student Name: _____

The following information is requested by the school nurse to plan an appropriate program for your child's needs in school, should any emergency situation arise. We would appreciate your completion of this form. Please note that:

- **Parent/Guardian is responsible for providing the school with any medication, or equipment that the student will require during the school day.**
- **If an individual school health care plan is indicated, Parent/Guardian is responsible for providing the school health nurse with the necessary medical information.**

Please check with the school's front office to obtain the correct medication and procedure forms.

Part 1. Parent/Guardian to complete during the registration process.

Student Information

Student's Name (Last):	Student's Name (First):	Middle initial:	Date of Birth:	Sex: Male Female
School:		Grade:	Teacher's Name:	

Parent Information

Parent/Guardian's Name:		Relationship to student:	Parent/Guardian Name:		Relationship to student:
Home phone #:	Cell phone #:	Work phone #:	Home phone #:	Cell Phone #:	Work phone #:
Emergency Contact Name:		Phone #:	Emergency Contact Name:		Phone #:

My Child has a medical condition that may affect his or her school day. ☐ No ☐ Yes (If yes, continue to part 2.)

Parent/Guardian Name (print) _____ Parent/Guardian Signature _____ [ate

Attention school staff; please return this form to the school nurse if parent checked "yes" above.

Part 2. Medical Information (Complete all boxes that apply to your child)

A. Medical History

☐Asthma	☐Allergies	☐Heart Disease	☐Diabetes
☐Seizures	☐Bladder/Kidney problems	☐Sickle Cell	☐ADD/ADHD
☐Vision problems	☐Hearing problems	☐Frequent Headaches	☐Orthopedic problems
☐Cancer	☐Hemophilic	☐Other (please specify): _____	

Does your child have a primary care physician? ☐ No ☐ Yes	Name of physician:	Physician's phone #:	Date of last appointment:

Does your child see a specialist? ☐ No ☐ Yes	Name of specialist :	Specialist's phone #:	Date of last appointment:
Does your child require activity restrictions? ☐ No ☐ **Yes, (<u>If yes, school must have medical documentation from a physician on file to accommodate any restrictions.</u>)**			

B. Medications: Please list all medications your child takes on a daily or as needed basis (use additional paper if more space is needed.)

Medication Name	How much	Time given	Side Effects

C. Allergies ☐ No ☐ Yes (If allergies are severe, please provide an allergy action plan from your child's physician.)

*Are the allergies: ☐Mild ☐Severe	What is your child allergic to? (Check all that apply)	Please Specify:
	☐ Foods:	
Date of Last Severe Reaction: ____/____/____	☐ Insect Stings/Bites:	
	☐ Medication:	
Allergy caused by: ☐ Ingestion ☐ inhalation ☐ contact	☐ Plants/Environmental:	
	☐Unknown	

Does your child have a food intolerance? If yes, please specify:_____

Please check all symptoms noted with allergic reaction:

☐ Redness	☐ Severe swelling	☐ Itching	☐ Hives
☐Breathing problems	☐Swelling of lips/face	☐Loss of consciousness	☐Nausea

If your child has a reaction, what do you do to treat the symptoms? _____

*Please list all medications your child takes for allergies in section B.

Has your child been prescribed an epinephrine auto-injector to be used in an emergency? ☐ No ☐ Yes

***It is recommended that an epinephrine auto-injector be provided to the school if the student has had a severe reaction in the past.**

D. Asthma ☐ No ☐ Yes (If yes, please provide an asthma action plan from your child's physician.)

Has your child ever been hospitalized due to asthma? ☐ No ☐ Yes If yes, when was last hospitalization? _____

What symptoms does your child experience during an asthma episode?

☐Difficulty breathing ☐ Coughing ☐ Wheezing ☐ Chest Pain/Discomfort ☐Other: _____

What triggers your child's asthma?: (check all that apply)			Currently prescribed medications:
	Trigger:	Please specify/explain:	☐ Inhaler (rescue)

	☐Exercise		☐ Inhaler (controller)
	☐Environmental		☐Nebulizer
	☐Foods		☐Oral steroids
	☐Unknown		☐Oral antihistamines
	☐Other		*Please list all medications in section B. ***It is recommended that an inhaler be provided to the school if the student has asthma.**

E. Diabetes ☐ No ☐ Yes (If yes, please provide a current Diabetes Medical Management Plan from your child's physician.)

Currently prescribed medications and treatments (check all that apply and list medications in section B.)

Insulin via: ☐ Syringe ☐ Pen ☐ Pump

☐ Blood sugar testing ☐Glucagon ☐Oral Medications ☐Continuous glucose monitoring

***It is recommended that a complete set of diabetic supplies (insulin, glucagon, fast acting sugar, protein snack, glucometer, etc.) be provided to the school for a student with diabetes even if the student has permission to self-carry these items.**

What symptoms does your child exhibit with **low** blood sugar?	What symptoms does your child exhibit with **high** blood sugar?
Does your child recognize the symptoms of a **low** blood sugar? ☐ No ☐ Yes	Does your child recognize the symptoms of a **high** blood sugar? ☐ No ☐ Yes

F. Seizure Disorder ☐ No ☐ Yes (If yes, please provide a seizure action plan from your child's physician.)

Type of Seizure: ☐Convulsive ☐ Non-Convulsive	What symptoms does your child have when having a seizure?		
Date of last seizure:	Length of seizure:	Known triggers:	Has diastat or other emergency seizure medication been prescribed by a physician? ☐ Yes ☐ No
Medications: Please list all medication student takes for seizures in section B.			
Are any physical activity restrictions required? ☐ No ☐ Yes ***If yes, school must have medical documentation from a physician on file to accommodate any restrictions.**			