

## **Enrollment Requirements for Freshmen new to the Poland Schools in 2017-18**

All of the documents listed below must be brought to the Guidance Office before any student will be scheduled for next year.

**Please call the Guidance Office at 330-757-7036  
to make an appointment to enroll and schedule your student.**

1. Completed Enrollment Form
2. Completed Health History Form
3. Completed Home Language Survey
4. Completed Proof of Residency Form – you must also provide proof of residency as stated on the form
5. Copy of 8<sup>th</sup> grade report card
6. Copy of Iowa Test or CogAt Test results – if available.
7. Birth Certificate
8. Custody papers (if applicable)
9. Schedule Request Form

# PSHS ANNUAL ENROLLMENT FORM

NOTE: Check here if student's/parent's address, phone, etc. has changed since last year. [ ]

STUDENT NAME \_\_\_\_\_ GRADE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_ GENDER \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ HOME PHONE NUMBER ( ) \_\_\_\_\_  
CURRENT ADDRESS \_\_\_\_\_ (Town) \_\_\_\_\_ (Zip) \_\_\_\_\_

**Required for State reporting purposes:** (if parent/guardian refuses to designate ethnicity/race the school district is required by the United States Department of Education to do so based on their observation of the student)

**Ethnicity:** Hispanic/Latino \_\_\_\_\_ yes \_\_\_\_\_ no (check one)

**Race:** (circle all that apply) White · Black/African American · Multi-Racial · Asian · American Indian/Alaskan Native · Native Hawaiian or Other Pacific Islander

The following information must be filled out **completely by the parent/guardian with whom the student resides:**

**Legal Custody:** \_\_\_\_\_ both parents \_\_\_\_\_ mother only \_\_\_\_\_ father only other (please specify) \_\_\_\_\_

**Lives with:** \_\_\_\_\_ both parents \_\_\_\_\_ mother only \_\_\_\_\_ father only other (please specify) \_\_\_\_\_

**Father's Name** \_\_\_\_\_ Living: Yes [ ] No [ ] Employer \_\_\_\_\_

Address \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ Living: Yes [ ] No [ ] Employer \_\_\_\_\_

Address \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**EMERGENCY INFORMATION:** Note: in case of an emergency and a **parent cannot be reached** with the information provided above, please provide the names and phone numbers of a responsible person we can contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

I hereby acknowledge reading the Poland Seminary High School Student Handbook – see link to Student Handbook at [www.polandbulldogs.com](http://www.polandbulldogs.com)

Student's signature **(required)** \_\_\_\_\_ date \_\_\_\_\_ Parent's signature **(required)** \_\_\_\_\_ date \_\_\_\_\_

**STUDENT RECORDS AND PRIVACY:** The Family Educational Rights and Privacy Act (FERPA), a federal law, requires the Poland Schools, with certain exceptions, obtain your written consent prior to the disclosure of personally identifiable information from your child's education records.

I acknowledge the right to decline the release of personally identifiable student data upon request to any third party (non-school related individual, agency or organization) by completing and returning the "Opt-out" form upon request from the office.

I also acknowledge my rights as a parent to inspect and review my child's educational records under the Family Educational Rights and Privacy Act (FERPA), and to request a hearing to challenge the accuracy of information contained in said record, with the opportunity for correction or deletion of inaccurate information or for the opportunity for insertion of a written explanation concerning the content of the records.

\_\_\_\_\_  
**PARENT'S/GUARDIAN'S SIGNATURE (required)**

\_\_\_\_\_  
**DATE**

**MAHONING COUNTY DISASTER SERVICES DIRECTED EARLY DISMISSAL:** In the event of an order from the Mahoning County Disaster Service directing the evacuation of the schools, parents will be notified via mass media of the directive and your student will be dismissed as per the following:

[ ] I grant the above named student permission to drive directly home upon dismissal from school. The following **siblings** may also leave with this driver.

[ ] I grant this student permission to ride home with their **sibling** \_\_\_\_\_ upon dismissal from school.

[ ] This student does not have permission to leave school without contacting one of the adults listed above.

\_\_\_\_\_  
**PARENT'S/GUARDIAN'S SIGNATURE**

\_\_\_\_\_  
**DATE**

# Ohio Department of Health • School and Adolescent Health

## Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth /   /
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**Family Health History** Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

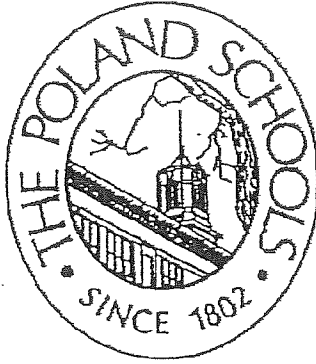
Father
Mother
Brothers and Sisters

**Birth and Developmental History**    No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly explain illness or problems.	
How does the child's development compare to other children, such as his or her brothers/sisters or playmates?	
<input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced	

**Student Health Conditions**

<input type="checkbox"/> <b>YES</b> , my child receives regular medical/health care for the following conditions:		<input type="checkbox"/> <b>NO</b> medical conditions
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Other _____
Please explain any conditions above or any reasons for hospitalizations.		
Please indicate any allergies your child may have.		
<b>Allergy type</b>	<b>Reaction</b>	<b>School restrictions or recommended actions</b>
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		



## HOME LANGUAGE SURVEY

Dear Parents/Guardians:

In order to determine the appropriate level of services for your son/daughter, please complete the following questionnaire:

Date: \_\_\_\_\_

NAME OF STUDENT: \_\_\_\_\_

DATE OF BIRTH: Month / Day / Year PLACE OF BIRTH: City State Country

NAME OF PARENT/GUARDIAN: Family Name First Name

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

*For Parents/Guardians:*

Please answer the following questions:

1. What language did your son/daughter speak when he/she first learned to talk? \_\_\_\_\_
2. What language does your son/daughter use most frequently at home? \_\_\_\_\_
3. What language do you use most frequently with your son/daughter? \_\_\_\_\_
4. What language do the adults at home most often speak? \_\_\_\_\_

Thanks for your time and attention to this matter. If you have any questions or concerns, please don't hesitate to call me at 330-757-7033.

Sincerely,

Craig R. Sommers  
Special Services Director  
The Poland Schools  
3199 Dobbins Road  
Poland, OH 44514

PROOF OF RESIDENCY FORM FOR POLAND SCHOOL DISTRICT

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Student's Name Birth Date Grade Sex

Legal Address:

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Number Street Home Telephone

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City State Zip Work Telephone

I certify that I, the parent/guardian of the above student are residents of the Poland School District and we reside at the address indicated. Residency is defined as the location at which you and the child sleep.

**IT IS A CRIMINAL OFFENSE SUBJECT TO FRAUD CHARGES TO FALSIFY RESIDENCY.**

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Signature of Parent/Guardian Date

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Please circle appropriate documentation presented – at least two items: one from each column.

Column 1

Column 2

1. House Closing Papers
2. Mortgage Documents
3. Apartment/Home Rental/Lease Agreement
4. Notarized Statement of Residency from Taxpayer

1. Two current utility bills
2. Two current charge statements
3. Drivers License
4. Voter Registration

ADDITIONAL INFORMATION/MATERIALS REQUIRED BY STATE LAW:

1. Birth Certificate
2. Proof of grade placement – report card or transcript
3. Proof of Custody (if applicable)
4. Proof of Immunization