

**GO FORTH BOLDLY!**

# • The Cincinnati College Preparatory Academy •

1425 LINN STREET CINCINNATI, OHIO 45214

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Middle Last

Former School: \_\_\_\_\_ Grade Applying for 2009-2010: \_\_\_\_\_

**THIS PACKETTE IS FOR *POTENTIAL CCPA STUDENTS ONLY*. ALL POTENTIAL STUDENTS MUST COMPLETE AN ADMISSION PACKET AND A PLACEMENT EXAM TO BE ENTERED INTO THE LOTTERY PROCESS FOR THE CCPA 2009-2010 SCHOOL YEAR.**

- All applicants must be 5 yrs old no later than September 30<sup>th</sup> of the current school year.

**Child Find Policy:** The school supports and complies with all applicable federal and state laws, procedures and policies regarding the School's child find responsibilities. The School will conduct all child find activities for students who are actually enrolled in the School so that they are appropriately located, identified and referred for evaluation.

Once a student has not participated in 105 consecutive hours of instruction, CCPA is obligated to automatically withdraw the student and notify the student's resident district.

- Application of Admission
- Contact Information (To be updated continually)
- Student Release Form
- Parent Questionnaire
- Personal Information
- Academic Information
- School Meals Application (**MUST BE COMPLETE W/\$ AMOUNTS**)
- Health History Form
- Physical Exam Form (**REQUIRED and must be signed by Physician**)
- Emergency Medical Authorization
- Prescription and Non- Prescription Medication Authorization (**Signed by Physician**)
- Transcript Release Form
- Community School Enrollment Form for CPS
- Birth Certificate and Social Security Card
- Proof of Legal Guardianship (
- Immunization Records
- Proof of Address (Utility bill, lease agreement...)

**Upon completion of the application all information must be submitted in its complete form. Incomplete applications will not be accepted. A placement exam will be scheduled after the application has been received. Upon completion of the placement exam the application will then be entered into the lottery drawing for admission**

OFFICE USE ONLY: App. Date received \_\_\_\_\_ Reviewed by: \_\_\_\_\_ Lottery Date: \_\_\_\_\_

Confirmed by/date: \_\_\_\_\_ Grade/Teacher Assigned: \_\_\_\_\_ / \_\_\_\_\_  
(Initials or name of Authorized Signee)



**Family Information**

**Father/Guardian:** \_\_\_\_\_ **Mother/Guardian:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_ **Business Address:** \_\_\_\_\_

**Business Phone:** \_\_\_\_\_ **Business Phone:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Home Address:** \_\_\_\_\_

**Home Ph:** \_\_\_\_\_ **Home Ph:** \_\_\_\_\_

**Who has legal custody of the child:** \_\_\_ **Father** \_\_\_ **Mother** \_\_\_ **Other:** \_\_\_\_\_

**\*Please note any other legal guardian other than the biological parent must present legal documents of the guardianship.**

**1<sup>st</sup> Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_

**2<sup>nd</sup> Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_

**Please describe any physical, emotional or mental conditions of the student applying for enrollment:**

\_\_\_\_\_

**PLEASE READ: \* ALL APPLICATIONS MUST BE COMPLETE AT THE TIME OF SUBMISSION TO THE SCHOOL. ANY APPLICATION THAT IS INCOMPLETE OR LACKS PROPER DOCUMENTATION WILL NOT BE PROCESSED OR ENTERED INTO THE LOTTERY. DATE OF SUBMISSION WILL HOLD NO INFLUENCE IN ANY CASE.**

**I have read and understand my responsibility as the Parent/Guardian of the applying student. All information must be completed by me and any physician as requested. Any information I fail to submit will result in my student’s application being withheld until I submit and/or complete the requested information.**

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## Contact Information

\_\_\_\_\_  
Date Student Name DOB

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Address City/State/Zip

Home Numbers: \_\_\_\_\_

Work Numbers: \_\_\_\_\_

Cell Numbers: \_\_\_\_\_

Other Numbers: \_\_\_\_\_

**In case of Emergency or if the school is unable to contact myself please contact the following people:**

1 \_\_\_\_\_  
Name Relationship to Child Telephone Number

\_\_\_\_\_  
Address City/State/Zip

2 \_\_\_\_\_  
Name Relationship to Child Telephone Number

\_\_\_\_\_  
Address City/State/Zip

3 \_\_\_\_\_  
Name Relationship to Child Telephone Number

\_\_\_\_\_  
Address City/State/Zip

**(LIST ANY ADDITIONAL CONTACTS ON THE BACK OF THIS FORM)**

**I understand that it is my responsibility to notify CCPA of any changes that may occur involving these contact people and phone numbers AS WELL AS my personal contact information.**

\_\_\_\_\_  
Parent/Guardian Signature



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## PARENT QUESTIONNAIRE

Child's Name: \_\_\_\_\_  
**First Middle Last**

Telephone : \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

Please explain if your child has any special diet needs, allergies, or medical needs?

\_\_\_ NO /YES \_\_\_\_\_

How will your child get to school? Please circle all that apply.

Car Walker Yellow Bus YMCA Van Other: \_\_\_\_\_

Are your child's immunizations up to date? \_\_\_ Yes \_\_\_ No \_\_\_ Not Sure

In case of an emergency, who should we contact? \_\_\_\_\_

Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Phone Numbers: Hm: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_

Does your child have any physical limitations? \_\_\_ No \_\_\_ Yes

If Yes, explain: \_\_\_\_\_

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Please indicate YES or NO.

My child may participate in activities, field trips and/or walking exercises within 1 mile radius of the school grounds. \_\_\_\_\_

In the event that photos are taken of the students for media publications, the school has my permission to use photos of my children. \_\_\_\_\_

I confirm that the information provided is true and that if any information is incorrect or incomplete, it could result in the loss of placement in the lottery or enrollment.

My relationship to the student that I am enrolling is: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

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## PERSONAL INFORMATION

**Student Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

*\*If your child is entering Kindergarten skip to question number 5*

1. Describe your child's previous classroom environment? (Warm, caring relationship w/teacher, friendships, academically challenging, etc)

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2. Has your child had any experiences that were physically, mentally, or emotionally damaging that may affect his/her academic performance or personal development? Please explain.

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3. How often have you been able to visit or be involved in your child's classroom? Please circle. Never      When  
requested    Volunteered: 1 time/yr    2- 5 times/year    More than 5 times

4. Describe the feelings you had during and after Parent Conferences with school staff.

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5. Has your child had any negative experiences at a school or day care?  No     Yes (Please explain if Yes:)

---

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6. How do you feel about school dress codes? \_\_\_\_\_

7. Name three must have's for your child's school. (3 things you must have for your child)

8. Name three can't have's for your child's school. (3 things you do not want for your child)

9. How does your child relate to other adults in authority? \_\_\_\_\_

10. How does your child relate to other children in and out of the classroom community?

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## ACADEMIC INFORMATION

**Student Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

*\*If your child is entering Kindergarten skip to question number 3*

1. Please explain if your child has an Individual Education Plan (IEP) or is he/she in need of receiving any special services?

\_\_\_\_\_

\_\_\_\_\_

2. Has your child ever had a Multi Factored Evaluation (MFE) or a Psychological/Educational Evaluation? When and with Whom?

\_\_\_\_\_

\_\_\_\_\_

3. Was your child in half day or full day Head Start and or Day Care or Kindergarten?

\_\_\_\_\_

4. How would you describe your child's current academic state? Please circle.

High    Average    Medium/Low    Low

Is your child on his/her current grade level in Math and Reading?    \_\_\_ Yes    \_\_\_ No    \_\_\_ Unsure

5. Has your child ever been held back a grade? Explain (include grade level)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Has your child ever been enrolled in an after school and/or summer program?

\_\_\_\_\_

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## **C.C.P.A. / Carl Lindner Family YMCA Swim Lesson Registration**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number \_\_\_\_\_

### **Please initial the following:**

\_\_\_\_\_ I understand that my son/daughter will participate in this swim program for a grade and will not be exempt without valid medical proof from his/her physician stating that he/she is unable to participate due to a physical ailment.

\_\_\_\_\_ I understand that personal grooming is not a valid excuse for being dismissed from participation.

\_\_\_\_\_ I understand that if my son/daughter fails to participate in the program without a valid excuse, as noted in the first statement, it will result in a failing grade for the course.

### **RELEASE WAIVER:**

I understand that the YMCA of Greater Cincinnati/CCPA assumes no responsibility for injuries or illnesses sustained as a result of my child's participation in any activities. I hereby release and discharge the YMCA of Greater Cincinnati/CCPA, its agents, servants, and employees from any and all claims for injury, illness, death, loss or damage, which my child may suffer as a result of his/her participation in these activities. I understand that the YMCA of Greater Cincinnati/CCPA is not responsible for personal property lost or stolen while members and/or program participants are using the YMCA facilities on YMCA/CCPA premises. I give my permission to the YMCA of Greater Cincinnati/CCPA to use indefinitely, without limitation or obligation, photographs, film, footage, or tape recordings, which may include my child's image or voice for the purpose of interpreting YMCA/CCPA programs. I acknowledge the waiver set forth above.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

File  
Separately

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1425

LINN STREET

CINCINNATI, OHIO 45214

Dear Parent/Guardian:

Children need healthy meals to learn. **Cincinnati College Preparatory Academy** offers healthy meals every school day. Breakfast costs **\$1.25**; lunch costs **\$2.25**. Your child may qualify for free meals or for reduced-price meals. Reduced-price is **\$.30** for breakfast and **\$.40** for lunch.

To apply for free or reduced-price meals, use the Free and Reduced-Price School Meals Application, which is enclosed. We cannot approve an application that is not complete, so be sure to fill out all required information. **Return this form with your completed application to: CCPA 1425 Linn St. Cincinnati, OH 45214.**

*Here are answers to questions you may have about applying:*

**1. Who can get free or reduced-price meals?** Children in households getting Food Stamps or OWF and most foster children can get free meals regardless of your income. Also, if your household income is within the limits on the Federal Income Chart, your child can get free or reduced price meals.

**2. Will the information I give be checked?** Yes, we may ask you to send written proof of the information you give.

**3. What if I stop getting Food Stamps or OWF?** If your child qualifies because you listed a Food Stamp or OWF case number, you must tell us when you no longer get Food Stamps or OWF.

**4. What if my household size or income changes?** If your child qualifies for free or reduced-price meals based on your income, you must tell us if your household size goes down or if your income goes up by more than \$50 per month (\$600 per year). Call us at **513-684-0777**. You do not have to fill out another application.

**5. If I don't qualify now, may I apply again later?** Yes. You may apply at any time during the school year if your household size goes up, income goes down, or if you start getting Food Stamps or OWF. If you lose your job, your child may be able to get free or reduced-price meals during the time you are unemployed.

**6. What if I disagree with the school's decision about my application?** You should talk to school officials. You also may ask for a hearing by calling or writing to: **CCPA, ATTN: REGISTRAR, 1425 Linn St. Cincinnati, OH 45214**

If you have other questions or need help, call **513-684-0777**.

Sincerely,

**Cincinnati College Preparatory Academy**

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## FREE AND REDUCED-PRICE SCHOOL MEALS APPLICATION INSTRUCTIONS

Use a separate application for each child.

### **If you are applying for a FOSTER CHILD, follow these instructions:**

**Part 1:** List the child's name, school, and grade.

**Part 2:** List the child's personal use monthly income, if any.

**Part 3:** Skip this part.

**Part 4:** Sign the form. A Social Security Number is not necessary.

**Part 5:** Answer this question if you choose to.

### **If your household gets FOOD STAMPS OR OWF, follow these instructions:**

**Part 1:** List your child's name, school, grade, and Food Stamp or OWF case number.

**DO NOT USE MEDICAID NUMBER OR OHIO DIRECTION CARD NUMBER**

**Part 2:** Skip this part.

**Part 3:** Skip this part.

**Part 4:** Sign the form. A Social Security Number is not necessary.

**Part 5:** Answer this question if you choose to.

### **ALL OTHER HOUSEHOLDS, follow these instructions:**

**Part 1:** List your child's name, school, and grade.

**Part 2:** Skip this part.

**Part 3:** Follow these instructions to report total household income from last month.

**Column 1–Name:** List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends). You must include yourself and all children. Attach another sheet of paper if you need to.

**Column 2–Last month's income and how often it was received:** List the types of income your household got last month and how often you got them. *Employment income:* List the **gross income** each person earned last month. It is not the same as take home pay. **Gross income is the amount earned before taxes and deductions.** It should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often you got it (weekly, every other week, twice a month, or monthly). *Other Income:* List the total amount each person got last month from **all other sources.** Include welfare, child support, alimony, pensions, retirement, Social Security, Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household, and **ANY OTHER INCOME.** Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it.

**Column 3–Check if no income:** If the person does not have any income, check the box.

**Part 4:** An adult household member must sign the form and list his or her Social Security Number, or mark the box if he or she doesn't have one.

**Part 5:** Answer this question if you choose to.

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## FREE AND REDUCED-PRICE SCHOOL MEALS APPLICATION

<b>Part 1. Child in School</b>					
Name of child in school (First, Middle Initial, Last)		School Name		Grade	Food Stamp or OWF case # (if any)
If you listed a Food Stamp/OWF case number for this child, skip to Part 3					
<b>Part 2. Foster Child</b>					
If this application is for a child who is the legal responsibility of a welfare agency or court, list the amount of the child's personal use monthly income: \$_____. Skip to Part 4.					
<b>Part 3. Total Household Income from Last Month—You must tell us how much and how often</b>					
<b>1. Name</b> (List <b>everyone</b> in household)	<b>2. Last month's income and how often it was received</b> <i>Example: \$100/monthly \$100/twice a month \$100/every other week \$100/weekly</i>				<b>3. Check if NO income</b>
	Earnings from work before deductions	Welfare, child support, alimony	Pensions, retirement, Social Security	Other	
<i>(Example)</i> <i>Jane Smith</i>	\$200/weekly	\$150/weekly	\$100/monthly	\$_____/_____	<input type="checkbox"/>
	\$_____/_____	\$_____/_____	\$_____/_____	\$_____/_____	<input type="checkbox"/>
	\$_____/_____	\$_____/_____	\$_____/_____	\$_____/_____	<input type="checkbox"/>
	\$_____/_____	\$_____/_____	\$_____/_____	\$_____/_____	<input type="checkbox"/>
	\$_____/_____	\$_____/_____	\$_____/_____	\$_____/_____	<input type="checkbox"/>
	\$_____/_____	\$_____/_____	\$_____/_____	\$_____/_____	<input type="checkbox"/>
	\$_____/_____	\$_____/_____	\$_____/_____	\$_____/_____	<input type="checkbox"/>
<b>Part 4. Signature and Social Security Number (Adult must sign)</b>					
An adult household member must sign the application. If Part 3 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)					
<i>I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my child may lose meal benefits, and I may be prosecuted.</i>					
Sign here: X _____ Date: _____					
Address: _____ Phone: _____					
Social Security Number: _____ - _____ - _____ <input type="checkbox"/> I do not have a Social Security Number					
<b>Part 5. Child's racial and ethnic identities (optional)</b>					
<u>Mark one or more racial identities:</u>					
<input type="checkbox"/> Black or African American		<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
				<input type="checkbox"/> White <input type="checkbox"/> Asian	
<u>Mark one ethnic identity:</u>					
<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Not Hispanic or Latino			
<b>Don't fill out this part. This is for school use only.</b>					
Monthly Income Conversion: Weekly x 4.33, Every 2 Weeks x 2.15, Twice A Month x 2					
Monthly Income: _____ Household size: _____ FS/OWF: _____ Date Withdrawn: _____ Eligibility: Free _____ Reduced _____ Denied _____					
Reason: _____ Temporary: Free _____ Reduced _____ Temporary Until: _____ (expires after _____ days) Approval Official's Signature: _____ Date: _____					

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## HEALTH HISTORY FORM

Student Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of Physician or Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Did any of the following problems affect this child? Please circle all that apply.

Problems with pregnancy      Pre-maturity  
Difficult delivery              Poor growth or slow development in infancy

Does your child have any of the following problems? Please circle all that apply.

Asthma                      Known vision or hearing loss              Convulsions or seizures  
Heart Trouble              Contact w/Tuberculosis                      Kidney Trouble  
Blood Disorders              Repeated Pneumonia                      Behavior Problems  
Hyperactivity              Rheumatic Fever                              Any Handicaps

Other health problems? \_\_\_\_\_

---

Has your child had any operations, serious accidents or hospitalizations? NO \_\_\_\_\_

If YES, explain: \_\_\_\_\_

Does your child take medications? NO \_\_\_\_\_

If YES, explain: \_\_\_\_\_

Circle any of the following childhood illnesses your child has had.

German Measles      Mumps      Polio      Whooping Cough      Tetanus  
Diphtheria              Mumps (10 Day)      Diphtheria              Chicken Pox

Has your child had any dental problems and/or toothaches? NO \_\_\_\_\_

If YES, explain: \_\_\_\_\_

Has your doctor recommended any restriction of activity for this child? NO \_\_\_\_\_

If YES, explain: \_\_\_\_\_

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## PHYSICAL EXAMINATION FORM 2009-2010 TO BE COMPLETED BY A PHYSICIAN

Student Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Head Size: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Examination Date: \_\_\_\_\_ Normal \_\_\_ Abnormal \_\_\_

Problems or Abnormalities: (ie.. Speech, Communication)

Development: \_\_\_ Normal \_\_\_ Abnormal Comments: \_\_\_\_\_

Hearing – Type of Test: \_\_\_\_\_

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

Results: \_\_\_ Normal \_\_\_ Abnormal

Comments: \_\_\_\_\_

Vision - Type of Test: \_\_\_\_\_

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

Results: \_\_\_ Normal \_\_\_ Abnormal

Comments: \_\_\_\_\_

Immunization Dates:

DPT \_\_\_\_\_

\_\_\_\_\_ Td \_\_\_\_\_

Oral Polio \_\_\_\_\_

Hb \_\_\_\_\_

MMR \_\_\_\_\_

Hepatitis B \_\_\_\_\_

Others \_\_\_\_\_

Tests:                      Date:                      Result:

Tuberculin                      \_\_\_\_\_                      \_\_\_\_\_

Hb/Hct                      \_\_\_\_\_                      \_\_\_\_\_

Sickle Cell                      \_\_\_\_\_                      \_\_\_\_\_

Lead                      \_\_\_\_\_                      \_\_\_\_\_

Urinalysis                      \_\_\_\_\_                      \_\_\_\_\_

Others                      \_\_\_\_\_                      \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Based upon an examination consistent with Cincinnati College Preparatory Academy this child is in suitable condition for enrollment.

Physician Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

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## Emergency Medical Authorization 2009-2010

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

### Residential Parent or Guardian:

\_\_\_\_\_  
Mother's Name (please print)

\_\_\_\_\_  
Daytime Telephone Number

\_\_\_\_\_  
Father's Name (please print)

\_\_\_\_\_  
Daytime Telephone Number

\_\_\_\_\_  
Other's Name (please print)

\_\_\_\_\_  
Daytime Telephone Number

Name of Relative or Childcare provider: \_\_\_\_\_

Relationship: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**Part I: TO GRANT CONSENT.** I hereby give consent for the following medical care providers and local hospitals to be called.

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_

Phone: \_\_\_\_\_

Medical Specialist: \_\_\_\_\_

Phone: \_\_\_\_\_

Local Hospital: \_\_\_\_\_

Phone: \_\_\_\_\_

In the event reasonable attempts have been unsuccessful, I hereby give consent for 911 the administration of any treatment deemed necessary by above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken and any physical impairments to which a physician should be alerted:

\_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**Part II: REFUSAL TO GRANT CONSENT.** I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring treatment, I wish the school to take the following action:

\_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**Dispensing Non- Prescription Medications at School 2009-2010**

A registered nurse is on duty part time to provide emergency and supplemental care for students. Students often have minor ailments and complaints that prohibit maximum effort in school, but can be eased, with simple over the counter remedies. The nurse may also use alternate methods of care (ice packs, rest) when possible.

We require written permission annually from you and your physician for each child, if our nurse is to give intermittent non-prescription remedies. Students who routinely use certain medications are encouraged to provide their own non-prescription medicine. This medicine will be kept in the Health and Wellness Office.

\_\_\_ YES, I hereby grant permission for the school nurse to dispense only those over the counter medications, which are checked below. I release the nurse and school personnel from any liability for the administration of said preparations.

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_  
 Parent/Guardian Signature Telephone Number Date

Physician, Please complete the medications you permit:

PAIN RELIEF	DOSAGE	FREQUENCY	INDICATIONS	REACTION
Ibuprofen	_____	_____	_____	_____
Acetamenophen (generic Tylenol)	_____	_____	_____	_____
<b>OTHER</b>				
Sudafed	_____	_____	_____	_____
Halls or Robitussin cough drops	_____	_____	_____	_____
Antacids (Rolaids, Mylanta, Tums)	_____	_____	_____	_____
Pepto-Bismol	_____	_____	_____	_____
Ammonia Inhalants	_____	_____	_____	_____
<b>TOPICALS</b>				
Vaseline	_____	_____	_____	_____
Triple Antibiotic Ointment	_____	_____	_____	_____
Caladryl or Benadryl	_____	_____	_____	_____
Hydrocortisone Cream 0.5 or 1%	_____	_____	_____	_____
Visine Eye Drops	_____	_____	_____	_____
Insect Sting Swabs	_____	_____	_____	_____
Solarcaine	_____	_____	_____	_____
Aloe Vera Gel	_____	_____	_____	_____
Orange	_____	_____	_____	_____
Sports Cream	_____	_____	_____	_____
OTHER: _____	_____	_____	_____	_____

List any drug allergies: \_\_\_\_\_

List all routine prescribed medications: \_\_\_\_\_

Physician Signature/Stamp \_\_\_\_\_ Date \_\_\_\_\_

**GO FORTH BOLDLY!**

• **The Cincinnati College Preparatory Academy** •

1425 LINN STREET CINCINNATI, OHIO 45214

**Dispensing Prescription Medications at School 2009-2010**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:**

Name of Medication(s): \_\_\_\_\_

Dosage: \_\_\_\_\_ Duration of Dosage: \_\_\_\_\_

How Administered: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

\_\_\_\_\_

Physician Signature/Stamp \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY THE PARENT:**

**The undersigned agree not to file or make any claim against anyone for the negligence in connection with the administration or non-administration of any medications and further agree to save such individuals and hold them harmless from liability incurred as a result of the administration or non-administration of any medications.**

**I give my permission for the Principal or his/her designee to administer the prescribed medication.**

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**GO FORTH BOLDLY!**

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1425 LINN STREET CINCINNATI, OHIO 45214

## Transcript Release Form

Applicant's Name: \_\_\_\_\_

Current School: \_\_\_\_\_

Current School Address: \_\_\_\_\_

Current School Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Current Grade Level: \_\_\_\_\_

**The following records may be released:**

- |   |  |
|---|--|
| <input type="checkbox"/> Transcript of subject and grades               | <input type="checkbox"/> Ohio Proficiency Test Results |
| <input type="checkbox"/> Attendance Record                              | <input type="checkbox"/> Standardized Test Results     |
| <input type="checkbox"/> Psychological or other Individual Test Results | <input type="checkbox"/> Health Records                |
| <input type="checkbox"/> IEP and Special Ed Records if applicable       |  |

I am the parent/guardian or custodian of the subject of these records and the subject is under 18 years of age. I hereby authorize the release of the requested records to:

ATTN: Enrollment/Records Department  
Cincinnati College Preparatory Academy  
1425 Linn St.  
Cincinnati, Ohio 45214

\_\_\_\_\_  
Parent/ Guardian Signature

\_\_\_\_\_  
Date

**To the Registrar:**

Please send the above records, if available for this student as soon as possible. If the records are not available, please return our request indicating the following:

No Records Available Reason(s):

\_\_\_\_\_  
 Unable to Send Records Reason(s):

\_\_\_\_\_  
Thank you for your prompt cooperation in helping us to secure the records of this student. Any further information that would help us better serve this student is greatly appreciated.

☆ CHARTER/COMMUNITY SCHOOL ☆

**STUDENT INFORMATION**

School Year \_\_\_\_\_ Today's Date **1**

School Name: Cincinnati College Prep Academy

School Code 963 \_\_\_\_/\_\_\_\_/\_\_\_\_

**Desired Action**

Enroll on Date \_\_\_\_/\_\_\_\_/\_\_\_\_ From \_\_\_\_\_  
 Withdraw on Date \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_\_  
 Modify Student Data as of \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Request for Transportation Services \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Submitted by (print) Andrea Watson Signed \_\_\_\_\_

**Student**

*Please provide legal names*

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Entering Grade Level \_\_\_\_\_

Gender ( check one)  Male  Female

Resident Address \_\_\_\_\_

Apartment \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Phone Number \_\_\_\_\_ Unl:  No  Yes

State \_\_\_\_\_

Birthdate (mm/dd/yyyy) \_\_\_\_\_

Birth Document Source \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (optional)

Ethnic Code  Black  White  Hispanic  
 Asian/Pacific Islander  Multi-Racial  
 Native American

Emergency Contact \_\_\_\_\_

Phone Numbers Home \_\_\_\_\_

Work \_\_\_\_\_

(CPS Use) \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

**Student ID**

Parent/Guardian Resident District if not CPS \_\_\_\_\_

**Transportation Requested Service**

Start Date \_\_\_\_\_

AM Pickup :  No AM Service Needed

Closest Stop to Home

Closest Stop to Daycare/Sitter

PM Drop Off  No PM Service Needed

Closest Stop to Home

Closest Stop to Daycare/Sitter

Name of Daycare/Sitter (if any) \_\_\_\_\_

Daycare/Sitter Address \_\_\_\_\_

Phone of Daycare/Sitter \_\_\_\_\_

Reason for Deviation \_\_\_\_\_

**Withdrawal Authorization**

Parent signature authorizes the Student Information Systems Department, Cincinnati Public Schools to withdraw this student from their current school of enrollment. I understand that this authorization will remove my child from the current school of enrollment and/or waiting list. There is no guarantee that my child will be re-enrolled if this current school is a magnet school and the charter school is no longer desired.

**Parent/Guardian Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

☆PRIVATE/PAROCHIAL ☆CHARTER/COMMUNITY SCHOOL ☆  
STUDENT REGISTRATION INFORMATION

Today's Date ②  
\_\_\_\_/\_\_\_\_/\_\_\_\_

Use additional pages as necessary.

Student Name \_\_\_\_\_

Mother  Father  Guardian  Stepparent  @ Foster parent  Grandparent  Surrogate Parent  Other

Last Name _____	Deceased? <input type="checkbox"/> No <input type="checkbox"/> Yes
First Name _____	District of Residence _____
(*)Mail Address _____	District of Primary Residence _____
City _____	Resides With Student <input type="checkbox"/> No <input type="checkbox"/> Yes
State _____	Custodial Parent <input type="checkbox"/> No <input type="checkbox"/> Yes
Zip Code _____	Legal Guardian <input type="checkbox"/> No <input type="checkbox"/> Yes
Phone Number _____ Unl: <input type="checkbox"/> No <input type="checkbox"/> Yes	Grandparent POA (see#) <input type="checkbox"/> No <input type="checkbox"/> Yes
Employer _____	Caregiver Authorization <input type="checkbox"/> No <input type="checkbox"/> Yes
Occupation _____	
Work Address _____	
Work Phone _____	Mail if not Custodial Parent? <input type="checkbox"/> No <input type="checkbox"/> Yes

Mother  Father  Guardian  Stepparent  @ Foster parent  Grandparent  Surrogate Parent  Other

Last Name _____	Deceased? <input type="checkbox"/> No <input type="checkbox"/> Yes
First Name _____	District of Residence _____
(*)Mail Address _____	District of Primary Residence _____
City _____	Resides With Student <input type="checkbox"/> No <input type="checkbox"/> Yes
State _____	Custodial Parent <input type="checkbox"/> No <input type="checkbox"/> Yes
Zip Code _____	Legal Guardian <input type="checkbox"/> No <input type="checkbox"/> Yes
Phone Number _____ Unl: <input type="checkbox"/> No <input type="checkbox"/> Yes	Grandparent POA (see#) <input type="checkbox"/> No <input type="checkbox"/> Yes
Employer _____	Caregiver Authorization <input type="checkbox"/> No <input type="checkbox"/> Yes
Occupation _____	
Work Address _____	
Work Phone _____	Mail if not Custodial Parent? <input type="checkbox"/> No <input type="checkbox"/> Yes

Mother  Father  Guardian  Stepparent  @ Foster parent  Grandparent  Surrogate Parent  Other

Last Name _____	Deceased? <input type="checkbox"/> No <input type="checkbox"/> Yes
First Name _____	District of Residence _____
(*)Mail Address _____	District of Primary Residence _____
City _____	Resides With Student <input type="checkbox"/> No <input type="checkbox"/> Yes
State _____	Custodial Parent <input type="checkbox"/> No <input type="checkbox"/> Yes
Zip Code _____	Legal Guardian <input type="checkbox"/> No <input type="checkbox"/> Yes
Phone Number _____ Unl: <input type="checkbox"/> No <input type="checkbox"/> Yes	Grandparent POA (see#) <input type="checkbox"/> No <input type="checkbox"/> Yes
Employer _____	Caregiver Authorization <input type="checkbox"/> No <input type="checkbox"/> Yes
Occupation _____	
Work Address _____	
Work Phone _____	Mail if not Custodial Parent? <input type="checkbox"/> No <input type="checkbox"/> Yes

(\*) If different from student's address

(#) If parent is not custodial, include copy of Grandparent Power of Attorney and Caregiver Authorization

@ If Foster parent, obtain copy of court order showing district of responsibility. Retain in cumulative file.