



FIRSTLINE SCHOOLS

NEW STUDENT ENROLLMENT PACKET

FOR SCHOOL USE ONLY

DATE RECEIVED: _____

FIRSTLINE SCHOOL (PLEASE CHECK ONE): ASHE GREEN LHA WHEATLEY CLARK

ENROLLMENT CHECKLIST:

- Firstline Schools Enrollment Form
- FirstLine Schools Confidential Records Release Form
- Firstline Schools Medical Release Form
- FirstLine Schools Health Screening Form (optional)
- FirstLine Schools Field Trip Authorization Form
- FirstLine Schools Media Release Form
- Louisiana Student Residency Questionnaire Form
- Louisiana Health Information Form
- Medicaid Reimbursement Notice and Consent Form (for Medicaid students only)
- Louisiana Office of Student Financial Assistance Form

DOCUMENT CHECKLIST:

- Copy of student's birth certificate
- Copy of student's social security card
(NOTE: This is optional, however high school students playing sports, applying to college and seeking job opportunities are strongly encouraged to provide a copy.)
- Copy of immunization records
- One proof of residence *(examples include: phone bill, water bill or lease agreement)*
- Copy of insurance or Medicaid card
- Copy of previous report card (if applicable)
- Copy of high school transcript (if applicable)

ADDITIONAL DOCUMENTS (IF APPLICABLE):

- IEP/504
- Copy of standardized test score(s)

In accordance with jurisprudence and applicable federal law, FirstLine Schools' student enrollment decisions are made without regard to a child's and/or his or her family's race, color, national origin, and citizenship and/or immigration status. No child will be denied enrollment due to an inability to produce the requested documentation because of his or her citizenship and/or immigration status, and/or homelessness.

**** Este encuesta está disponible en español. ****

**** Hình thức này có sẵn bằng tiếng Việt. ****

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

HOW DID YOU HEAR ABOUT US?

CHECK ALL THAT APPLY

A friend

Another FirstLine Family

Please list the family: _____

Advertisement (bus shelter, billboard, etc.)

Event

Please list the event: _____

Radio

Flyer, postcard or mailer

Social media (Facebook, Twitter, Instagram)

STUDENT INFORMATION

GENDER: FEMALE MALE

SOCIAL SECURITY NUMBER
(OPTIONAL)

— —

CURRENT GRADE

CURRENT SCHOOL

CITY, STATE

ENROLLING IN (PLEASE SELECT ONE):

ARTHUR ASHE CHARTER SCHOOL

SAMUEL J. GREEN CHARTER SCHOOL

LANGSTON HUGHES ACADEMY

PHILLIS WHEATLEY COMMUNITY SCHOOL

JOSEPH S. CLARK PREPARATORY HIGH SCHOOL

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

PARENT/GUARDIAN CONTACT INFORMATION

PARENT/GUARDIAN NAME (LAST, FIRST)	RELATIONSHIP TO STUDENT		
()	()		
PRIMARY PHONE	SECONDARY PHONE		
EMAIL			
ADDRESS (NUMBER, STREET)	CITY	STATE	ZIP CODE
PREFERRED METHOD OF CONTACT: <input type="checkbox"/> PHONE <input type="checkbox"/> TEXT <input type="checkbox"/> EMAIL <input type="checkbox"/> ALL			

FIRSTLINE SCHOOLS ENROLLMENT FORM - RETURN TO FRONT OFFICE

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

INDIVIDUALS ALLOWED TO CHECK OUT THE STUDENT

NAME (FIRST, LAST)	RELATIONSHIP TO STUDENT	PHONE	EMAIL	LIVES WITH STUDENT?
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO

INDIVIDUALS NOT ALLOWED TO CHECK OUT THE STUDENT

NAME (FIRST, LAST)	RELATIONSHIP TO STUDENT	PHONE	EMAIL	LIVES WITH STUDENT?
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

SCHOOL HISTORY

MOST RECENT SCHOOL ATTENDED

SCHOOL ADDRESS

CITY, STATE

YEAR(S) ATTENDED

PRIOR SCHOOL NAME

SCHOOL ADDRESS

CITY, STATE

YEAR(S) ATTENDED

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

TRANSPORTATION SERVICES

FirstLine Schools provides transportation services to all students who live in Orleans Parish, *at least* one mile from school. To ensure the safety of our students, we follow the below protocols for student *bus drop off*:

- Students who require specific transportation accommodations will not be released at their bus stop unless an approved caretaker is present at the bus stop. If an approved caretaker is not present, the student will be returned to the school for pick-up.
- Students in grades three and below will not be released at their bus stop unless a parent or guardian is present at the bus stop. An older sibling may accompany the student if authorized by the child's parent or guardian. If a parent, guardian or approved sibling is not present, the student will be returned to the school for pick-up.

Please indicate below how student will arrive (AM) and depart (PM) from school.

ARRIVAL (AM)	<input type="checkbox"/> WALK <input type="checkbox"/> CAR <input type="checkbox"/> SCHOOL BUS	DEPART (PM)	<input type="checkbox"/> WALK <input type="checkbox"/> CAR <input type="checkbox"/> SCHOOL BUS
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If you selected "School Bus" for arrival or depart, please provide an address below:

AM PICK UP ADDRESS:

ADDRESS (NUMBER, STREET)	CITY	STATE	ZIP CODE
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PM DROP OFF ADDRESS:

ADDRESS (NUMBER, STREET)	CITY	STATE	ZIP CODE
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If the address(es) above change, please complete a change of address form and return to the front office.

PARENT/GUARDIAN NAME (FIRST, LAST)	SIGNATURE	DATE
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STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

RACE & ETHNICITY SURVEY

STUDENT'S PLACE OF BIRTH: (CITY, STATE, COUNTRY)

IF STUDENT'S PLACE OF BIRTH IS OUTSIDE THE U.S. PLEASE PROVIDE DATE OF ARRIVAL TO THE U.S. BELOW

MONTH: _____

YEAR: _____

IS THE STUDENT HISPANIC OR LATINO? YES NO

WHAT IS THE STUDENT'S RACE (SELECT ALL THAT APPLY)

- AFRICAN AMERICAN/BLACK
- AMERICAN INDIAN/ALASKAN NATIVE
- ASIAN
- NATIVE HAWAIIAN OR PACIFIC ISLANDER
- WHITE
- DECLINE TO STATE
- OTHER

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

HOME LANGUAGE SURVEY

The Louisiana Education Code requires that all schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

1. Is a language other than English used at the student's home? YES NO

2. *If you selected NO, skip to the end* If **YES**, what language? _____

3. How often is this language spoken? More often than English Less often than English

4. What language is spoken by adults in the student's home? _____

5. What is the first language the student learned to speak? _____

6. Does you or your student need translation services? YES NO

If you selected yes, which language? _____

7. Do you need an interpreter for concerns involving your student's education? YES NO

If you selected yes, which language? _____

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

STUDENT NEEDS SURVEY

Please provide as much information on your student so we can provide the appropriate services. Your responses will have no impact on your student's admittance into school, as your student has already been accepted.

SPECIAL EDUCATION - 504 - IEP	YES	NO	DONT KNOW
My student has received special education services.			
I would like for my student to be evaluated for special education services.			
My student has an in Individual Education Plan (IEP).			
<i>*If you selected YES, please provide a copy of the student's IEP or list which school would have a copy of the student's IEP.</i>			
My student receives services under the 504 Rehabilitation Act.			
My student has been evaluated for special education services.			
<i>*If you selected YES, please provide the evaluation date:</i>			

ADDITIONAL INFORMATION	YES	NO	NOTES
My student has been retained. <i>If you select YES, please provide which grade(s).</i>			
My student has been suspended. <i>If you select YES, please provide the reason and number of times.</i>			
My student has been expelled. <i>If you select YES, please provide the reason, number of times, date and from which school.</i>			

ADDITIONAL COMMENTS:

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

MEDICAL RELEASE FORM

INSURANCE PROVIDER & GROUP NUMBER

PLAN

PRIMARY INSURED

INSURE DOB (MM/DD/YYYY)

EMPLOYER

PRIMARY CARE PHYSICIAN

HOSPITAL/CLINIC OF PREFERENCE

I, the undersigned parent/guardian, hereby grant the staff of FirstLine Schools the authority to obtain medical treatment for the child listed above. This includes authorization to obtain medical treatment and procedures for the child as may be appropriate in emergency circumstances, including treatment by physicians, hospital, clinic, and paramedic personnel. I waive my right to informed consent of treatment, only in the event that I cannot be reached.

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

HEALTH SCREENING AUTHORIZATION (OPTIONAL)

Your child's health and well-being are important to us. We want to assist you in ensuring that all students are provided with the tools that they need for success. To that end, we have compiled a list of vendors that we maintain relationships with. With your consent, they can provide the listed services. All services are optional and coordinate with school nursing services. By signing below, you authorize coordination of services for your child during the school year. You may opt out at any time.

VISION SERVICES

On Site Eye Care
Tots and Teens EyeCare
Dr. Daphe Richardson
For Your Eyes Only 20/20
Dr. Jeff Silbernagel

AUDIOLOGY SCREENS

The Lion's Club
New Orleans Speech and
Hearing
Dr. Joe Melcher (Xavier
University)
Nurse Nikki LLC
LSU Audiology Clinic

DENTAL SCREENS

Gentilly Family Dental LLC
Dr. Ambrose Martin DDS
Mobile Dental Unit (Children's)
Dr. Jimani Mwendu DDS

EYE HISTORY (CHECK IF APPLICABLE):

- Eye Surgery Eye Turn (Strabismus) Itching Injury Other

Complete Assessment may involve eye dilation. This may cause light sensitivity/blur for 3-4 hours. Disposable sunglasses will be provided.

- YES, I give permission for dilation
 NO, I prefer my student's eyes not be dilated

HEARING & DENTAL HISTORY (CHECK IF APPLICABLE):

- Latex Allergy Congenital Hearing Difficulty Hearing Aids Other

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

FIRSTLINE SCHOOLS FIELD TRIP AUTHORIZATION FORM

I permit my student to participate in field trips while they are enrolled at FirstLine Schools.

I understand that the school will take all reasonable precautions to ensure against the possibility of accidents. However, I understand that this school or the adult in charge is not liable for accidents occurring to children either on school premises or while on field trips as part of the school's activities.

Information concerning a specific field trip such as date, time of departure, destination, cost, and means of transportation will be sent to me by the teacher prior to each field trip.

FIRSTLINE SCHOOLS ENROLLMENT FORM - RETURN TO FRONT OFFICE

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

FIRSTLINE SCHOOLS MEDIA RELEASE FORM

Throughout the school year, students may be highlighted in efforts to promote FirstLine Schools' and its affiliated schools' activities and achievements. For example, students may be featured in materials to train teachers and/or increase public awareness of our schools through newspapers, radio, TV, the web, DVDs, displays, brochures, billboards, social media, and other types of media. There may also be times while my child is enrolled in a FirstLine school where outside media or others may visit the school or school event and wish to photograph, videotape, or interview the child.

As the parent or guardian, I hereby give FirstLine Schools and its employees, representatives, contracted employees, authorized volunteers, and authorized local and national media organizations (including but not limited to newspaper outlets, magazines, television, and other media) permission to print, photograph, and record my child for use in audio, video, film, or any other electronic, digital and printed media. This is with the understanding that I will not receive monetary compensation for my child's participation, and I further release and hold harmless FirstLine Schools, its Board of Directors, employees, the photographer, videographer, and other representatives from any future claims and liabilities, known or unknown, arising out of the use of this material.

I understand that by signing this waiver I agree to my child's image and likeness being used in educational, promotional and marketing materials, on social media sites such as Twitter, Facebook, Instagram, blogs, in press releases, on websites, radio stations, news stations, on television, and any other media outlet.

I certify that I have read the Media Consent and Release Liability statement and fully understand its terms and conditions.

Please note that this release applies from the date of signing and remains in effect perpetually. FirstLine Schools may use these images, videos, audio, likeness, etc. in the afore-described manner even after your child no longer attends a FirstLine school. Should you no longer agree to your child's image and likeness being used, you will have to sign and return the opt-out form.

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

FIRSTLINE SCHOOLS CONFIDENTIAL RECORDS RELEASE

Authorization to release student information as per the United States Code "Family Educational Rights and Privacy Act."

This form gives FirstLine Schools permission to request your student's educational records from any previous school(s).

SCHOOL REGISTRAR OR COUNSELOR:

You are hereby authorized to release the following information regarding the student listed above (check all that apply):

- Standardized test data
- Scholastic achievement data
- Medical data and immunization records
- Birth certificate
- Social security number
- IEP records

SCHOOL HISTORY				
	GRADE	SCHOOL NAME	CITY, STATE	YEAR(S) ATTENDED
1				
2				
3				
4				
5				

I authorize FirstLine Schools to request educational records for my student from any previous school(s).

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE



Louisiana Student Residency Questionnaire Form (Form Must Be Included In School Enrollment Packet)

Date District/Parish School Name Student Name SSN/ID# Male/Female Date of Birth Address Telephone Number Last School Attended Current Grade Parent/Guardian/Adult Caring for Student Relationship

Disclaimer: This questionnaire is intended to address the McKinney-Vento Act. Your child may be eligible for additional educational services through Title I Part A, Title I Part C-Migrant, Individuals with Disabilities Education Act (IDEA) and/or Title X, Part C, Federal McKinney-Vento Assistance Act, 42 U.S.C.11435. Eligibility can be determined by completing this questionnaire. It is illegal to knowingly make false statements on this form. If eligible, students are to be immediately enrolled in accordance with Bulletin 741, section 341.

- 1. Yes No Is the student's address a temporary living arrangement? (Note: If this is a permanent living arrangement or the family owns or rents their home, sign under item 9 and submit form to school personnel.)
2. Yes No Is the temporary living arrangement due to loss of housing or economic hardship?
3. Where is the student currently living? (Check all that apply)

Form box containing checkboxes for housing types: In an emergency/transitional shelter, Temporarily with another family because we cannot afford or find affordable housing, With an adult that is not a parent or legal guardian, or alone without an adult, In a vehicle of any kind, trailer park or campground without running water/electricity, abandoned building or substandard housing, Emergency Housing (i.e. FEMA Trailer or FEMA Rental Assistance), In a hotel/motel, Other specific information

- 4. Yes No Does your child have a disability or receive any special education services? (Check One)
5. Yes No Does your child exhibit any behaviors that may interfere with his or her academic performance?
6. Would you like assistance with uniforms student records school supplies transportation other? (Describe:)
7. Yes No Migrant - Have you moved at any time during the past three (3) years to seek temporary or seasonal work in agriculture (including poultry processing, dairy, nursery, and timber) or fishing?
8. Yes No Does your child have siblings? Name Grade Name Grade Name Grade Name Grade
9. The undersigned certifies that the information provided above is accurate.

Print Parent/Guardian Name/Adult Caring for Student Signature Date
(Area Code) Phone number Street Address City State Zip

School Use Only Free or Reduced Price Meals Form submitted/signed Copy Placed in Student's Cumulative Record
Homeless Liaison Use Only- Check All That Apply
Sheltered Doubled-Up Unsheltered/FEMA Hotel/Motel Unaccompanied youth Yes No

Print School Contact Title Signature (required) Date (Revised 3/2010)

FIRSTLINE SCHOOLS ENROLLMENT FORM - RETURN TO FRONT OFFICE

STATE OF LOUISIANA

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.				
Name of School:			Grade:	
Student's Name: Last		First		M.I.
Student's Date of Birth:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	State or Country of Birth:	
Student's Mailing Address:		City:	State:	Zip Code:
Student's Physical Address:		City:	State:	Zip Code:
Name of Mother or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:
Name of Father or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:
Name of child's pediatrician or primary care provider:		Names of medical specialists or special clinics caring for your child:		
Parent or Legal Guardian Signature				Date
Please check the type of health insurance your child has: <input type="checkbox"/> Private <input type="checkbox"/> Medicaid/LaCHIP <input type="checkbox"/> None				
If your child does not have health insurance, would you like information on no cost health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
In case of emergency—if parent or legal guardian cannot be reached—contact the following:				
Name		Complete Phone Number ()		
My child has a medical, mental, or behavioral condition that may affect his/her school day: <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please complete Part 2.)				
PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.				
<input type="checkbox"/> ALLERGIES				
Allergy Type:				
<input type="checkbox"/> Food (list food(s)) _____				
<input type="checkbox"/> Insect sting (list insect(s)) _____				
<input type="checkbox"/> Medication (list medication(s)) _____				
<input type="checkbox"/> Other (list) _____				
Reactions: (Date of last occurrence if yes.)				
<input type="checkbox"/> Coughing (Date: _____)		<input type="checkbox"/> Hives (Date: _____)		<input type="checkbox"/> Rash (Date: _____)
<input type="checkbox"/> Difficulty breathing (Date: _____)		<input type="checkbox"/> Local swelling (Date: _____)		<input type="checkbox"/> Wheezing (Date: _____)
<input type="checkbox"/> Generalized swelling (Date: _____)		<input type="checkbox"/> Nausea (Date: _____)		<input type="checkbox"/> Other (Date: _____)
Currently prescribed medications and treatments:				
<input type="checkbox"/> Oral antihistamine (Benadryl, etc.) <input type="checkbox"/> Epi-pen <input type="checkbox"/> Other _____				
<input type="checkbox"/> ASTHMA				
Triggers: <input type="checkbox"/> Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ <input type="checkbox"/> Other (list) _____				
Does your child experience asthma symptoms with exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Symptoms:				
<input type="checkbox"/> Chest tightness, discomfort, or pain <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Coughing <input type="checkbox"/> Wheezing <input type="checkbox"/> Other _____				
Currently prescribed medications and treatments: _____				
Date of last hospitalization related to asthma _____ Date of last emergency room visit related to asthma _____				
Does your child have a written asthma management plan? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Is peak flow monitoring used? <input type="checkbox"/> No <input type="checkbox"/> Yes				

<input type="checkbox"/> DIABETES	
Currently prescribed medications and treatments:	
<input type="checkbox"/> Insulin: <input type="checkbox"/> Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Pump <input type="checkbox"/> Blood sugar testing <input type="checkbox"/> Glucagon <input type="checkbox"/> Oral medication(s) List medication(s) _____	
Is special scheduling of lunch or Physical Education required? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> SEIZURE DISORDER	
Type of seizure:	
<input type="checkbox"/> Absence (staring, unresponsive) <input type="checkbox"/> Complex Partial <input type="checkbox"/> Generalized Tonic-Clonic (Grand Mal/Convulsive) <input type="checkbox"/> Other (explain) _____	
Physical Education Restrictions: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Medication(s): <input type="checkbox"/> No <input type="checkbox"/> Yes List medication(s) _____	
Date of last seizure _____	Length of seizure _____
<input type="checkbox"/> OTHER HEALTH CONDITIONS	
<input type="checkbox"/> Anemia <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Cancer <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Depression <input type="checkbox"/> Digestive disorders <input type="checkbox"/> Emotional/Psychological <input type="checkbox"/> Juvenile Rheumatoid Arthritis <input type="checkbox"/> Hemophilia <input type="checkbox"/> Heart condition <input type="checkbox"/> Physical disability <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Skin disorders <input type="checkbox"/> Speech problems <input type="checkbox"/> Other (explain) _____	
Physical Education Restrictions: <input type="checkbox"/> No <input type="checkbox"/> Yes (explain): _____	
Medication(s): <input type="checkbox"/> No <input type="checkbox"/> Yes List medication(s) _____	
Special procedures required (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning): <input type="checkbox"/> No <input type="checkbox"/> Yes (explain): _____	
Special diet required (i.e., blended, soft, low salt, low fat, liquid supplement): <input type="checkbox"/> No <input type="checkbox"/> Yes (explain): _____	
Are there anticipated frequent absences or hospitalizations? No Yes (explain): _____	
<input type="checkbox"/> VISION CONDITIONS	<input type="checkbox"/> HEARING CONDITIONS
<input type="checkbox"/> Contacts/glasses <input type="checkbox"/> Other _____	<input type="checkbox"/> Hearing aid(s) <input type="checkbox"/> Other _____
<input type="checkbox"/> ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION	
Special school environmental adjustments of the school environment or schedule: <input type="checkbox"/> No <input type="checkbox"/> Yes (explain): _____	
(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)	
Special school environmental adjustments to classroom or school facilities: <input type="checkbox"/> No <input type="checkbox"/> Yes (explain): _____	
(i.e., temperature control, refrigeration/medication storage, availability of running water)	
Special safety considerations: <input type="checkbox"/> No <input type="checkbox"/> Yes (explain): _____	
(i.e., special precautions in lifting, positioning, special transportation emergency plan, special safety equipment, special techniques for positioning, feeding)	
Special assistance with activities of daily living: <input type="checkbox"/> No <input type="checkbox"/> Yes (explain): _____	
(i.e., eating, toileting, walking)	
PART 3: SCHOOL NURSE TO COMPLETE if parent/legal guardian indicates medical condition.	
_____	_____
School Nurse Signature	Date
Notes:	

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

NOTICE AND CONSENT REGARDING MEDICAID REIMBURSEMENT
(FOR MEDICAID STUDENTS ONLY)

NOTICE

The Louisiana Department of Health and Hospitals (DHH) Medicaid program allows school districts to request reimbursement for costs associated with provision of certain IEP-related services. These services include occupational and physical therapy, speech pathology, behavioral health services, nursing services, and special transportation.

Schools are required to provide notice and to obtain consent from a parent before accessing a child's Medicaid benefits.

FirstLine Schools seeks your consent to disclose personally identifiable information about your child to Louisiana Medicaid to access reimbursement for the IEP/Medicaid covered health services that are provided at school. In order to submit claims for IEP/Medicaid covered services, the following types of records may be required: child's full name, address, date of birth, Medicaid ID, disabilities, types of services and dates of services delivered. This disclosure of information to Louisiana Medicaid and its affiliates and access to Medicaid reimbursement for the school district shall not result in any decrease in available lifetime Medicaid coverage, result in any cost to you or your family, increase any premiums or lead to the discontinuation of your child's benefits or insurance or create any risk of loss of your child's eligibility for home and community-based waivers based on total health related expenditures.

You may withdraw this consent in writing at any time. If you refuse consent or withdraw consent to allow access to the Medicaid benefits, it will not relieve the school system of its responsibility to ensure that all required IEP services are provided at no cost to your child.

CONSENT

I hereby authorize FirstLine Schools to disclose necessary information to Louisiana Medicaid in order to seek reimbursement for the IEP/Medicaid-covered health services provided to my child.

PARENT/GUARDIAN NAME (FIRST, LAST)

SIGNATURE

DATE

STUDENT'S LAST NAME

STUDENT'S FIRST NAME

DATE OF BIRTH

LOUISIANA OFFICE OF STUDENT FINANCIAL ASSISTANCE CONSENT FORM

TOPS, COLLEGE SCHOLARSHIPS, GRANTS, AID PROGRAMS & COLLEGE ADMISSIONS

If you consent, your child's data will be shared with the Louisiana Office of Student Financial Assistance (LOSFA) through the Louisiana Department of Education (LDE) and its technology partner, the Office of Technology Services (OTS) and the postsecondary education institution(s) to which your child applies (Institution) through the Board of Regents (BOR), LDE, and OTS to allow:

- You to track your child's progress in taking the courses and earning the grades required to be eligible for a Taylor Opportunity Program for Students (TOPS) Scholarship.
- By having an account on Louisiana Connect (www.LouisianaConnect.org).
- LOSFA to determine whether your child is eligible for TOPS and other college aid using the Louisiana Award System (LAS).
- You to monitor your child's TOPS eligibility status by having an account on LAS (www.osfa.la.gov/AwardSystem/).
- LOSFA to make TOPS and other aid payments.
- The Institution(s) to process his/her application for admission.

The data which is necessary to determine your child's eligibility for TOPS and for admission to an Institution and which may be shared with LOSFA and Institutions for these purposes includes:

- Full name
- Birth date
- Social Security Number
- Student transcript data (includes but not limited to courses taken, type of course, the grades for each course, and when and where the courses were taken).

If you do not consent to the disclosure of your child's data to LOSFA and to postsecondary Institutions, the evaluation of your child's eligibility for TOPS and for admission to college will be delayed until the information necessary to make a determination is provided.

I CONSENT to my child's school collecting my child's personal information named above and disclosing the personal information collected to LOSFA, to the Institution, and to the entities named above. I understand and acknowledge that the consent provided herein shall be valid for my child's cumulative transcript records as of the date of signature and shall remain valid and in effect until he graduates from high school or I withdraw consent by completing the bottom portion of this form and returning it to my child's school.

PARENT/GUARDIAN NAME (FIRST, LAST)	SIGNATURE	DATE
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I DO NOT CONSENT to my child's school collecting my child's personal information named above and disclosing the personal information to LOSFA and BOR. I understand that I may provide consent at a later date by completing the consent portion of this form above and returning it to my child's school.

PARENT/GUARDIAN NAME (FIRST, LAST)	SIGNATURE	DATE
------------------------------------	-----------	------