FIRSTLINE SCHOOLS
RETURNING STUDENT ENROLLMENT PACKET

FOR SCHOOL USE ONLY

DATE RECEIVED: _____

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

ENROLLMENT CHECKLIST:

- ☐ Firstline Schools Re-enrollment Form
- ☐ FirstLine Schools Health Screening Form (optional)
- ☐ Louisiana Student Residency Questionnaire Form
- ☐ Louisiana Health Information Form
- ☐ Medicaid Reimbursement Notice and Consent Form (for Medicaid students only)

DOCUMENT CHECKLIST:

- ☐ Copy of student's birth certificate
- ☐ Copy of immunization records
- ☐ One proof of residence *(examples include: phone bill, water bill or lease agreement)*
- ☐ Copy of insurance or Medicaid card

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

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: ☐ PHONE ☐ TEXT ☐ EMAIL ☐ ALL	

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

STUDENT'S LAST NAME | STUDENT'S FIRST NAME | DATE OF BIRTH

EMERGENCY CONTACT INFORMATION

NAME (FIRST, LAST) ( )	RELATIONSHIP TO STUDENT ( )
HOME PHONE	SECONDARY PHONE
EMAIL	
ADDRESS (NUMBER, STREET)	CITY STATE ZIP CODE

NAME (FIRST, LAST) ( )	RELATIONSHIP TO STUDENT ( )
HOME PHONE	SECONDARY PHONE
EMAIL	
ADDRESS (NUMBER, STREET)	CITY STATE ZIP CODE

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

FIRSTLINE SCHOOLS ENROLLMENT FORM - RETURN TO FRONT OFFICE

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?**
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

INDIVIDUALS **NOT ALLOWED** TO CHECK OUT THE STUDENT				
NAME (FIRST, LAST)	**RELATIONSHIP TO STUDENT**	**PHONE**	**EMAIL**	**LIVES WITH STUDENT?**
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

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)		**DEPART** (PM)	
	☐ WALK ☐ CAR ☐ SCHOOL BUS		☐ WALK ☐ CAR ☐ SCHOOL BUS

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

PM DROP OFF ADDRESS:

ADDRESS (NUMBER, STREET) | CITY | STATE | ZIP CODE

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

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 Mwendo 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

Louisiana Department of EDUCATION

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)

   ☐ 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_____
   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: ☐ M ☐ 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: ☐ Private ☐ Medicaid/LaCHIP ☐ None

If your child does not have health insurance, would you like information on no cost health insurance? ☐ Yes ☐ 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: ☐ No ☐ 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.

❑ ALLERGIES

Allergy Type:

- ☐ Food (list food(s)) _____
- ☐ Insect sting (list insect(s)) _____
- ☐ Medication (list medication(s)) _____
- ☐ Other (list) _____

Reactions: (Date of last occurrence if yes.)

- ☐ Coughing (Date:) ☐ Hives (Date:) ☐ Rash (Date:)
- ☐ Difficulty breathing (Date:) ☐ Local swelling (Date:) ☐ Wheezing (Date:)
- ☐ Generalized swelling (Date:) ☐ Nausea (Date:) ☐ Other _____ (Date:)

Currently prescribed medications and treatments:

☐ Oral antihistamine(Benadryl, etc.) ☐ Epi-pen ☐ Other _____

❑ ASTHMA

Triggers: ☐ Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ ☐ Other (list) _____

Does your child experience asthma symptoms with exercise? ☐ No ☐ Yes

Symptoms:

☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Coughing ☐ Wheezing ☐ 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? ☐ No ☐ Yes

Is peak flow monitoring used? ☐ No ☐ Yes

Name: _____ DOB: _____

❑ **DIABETES**

Currently prescribed medications and treatments:

☐ Insulin: ☐ Syringe ☐ Pen ☐ Pump
☐ Blood sugar testing
☐ Glucagon
☐ Oral medication(s) List medication(s) _____

Is special scheduling of lunch or Physical Education required? ☐ No ☐ Yes

❑ **SEIZURE DISORDER**

Type of seizure:

☐ Absence (staring, unresponsive) ☐ Complex Partial ☐ Generalized Tonic-Clonic (Grand Mal/Convulsive)
☐ Other (explain) _____

Physical Education Restrictions: ☐ No ☐ Yes

Medication(s): ☐ No ☐ Yes List medication(s) _____

Date of last seizure _____ Length of seizure _____

❑ **OTHER HEALTH CONDITIONS**

☐ Anemia ☐ ADD/ADHD ☐ Cancer ☐ Cerebral Palsy ☐ Chicken Pox ☐ Cystic Fibrosis
☐ Depression ☐ Digestive disorders ☐ Emotional/Psychological ☐ Juvenile Rheumatoid Arthritis
☐ Hemophilia ☐ Heart condition ☐ Physical disability ☐ Sickle Cell Disease ☐ Skin disorders
☐ Speech problems ☐ Other (explain)_____

Physical Education Restrictions: ☐ No ☐ Yes (explain): _____

Medication(s): ☐ No ☐ Yes List medication(s) _____

Special procedures required (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning): ☐ No ☐ Yes (explain):_____

Special diet required (i.e., blended, soft, low salt, low fat, liquid supplement): ☐ No ☐ Yes (explain): _____

Are there anticipated frequent absences or hospitalizations? No Yes
(explain):_____

❑ **VISION CONDITIONS**

☐ Contacts/glasses
☐ Other _____

❑ **HEARING CONDITIONS**

☐ Hearing aid(s)
☐ Other _____

❑ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**

Special school environmental adjustments of the school environment or schedule: ☐ No ☐ 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: ☐ No ☐ Yes (explain):_____

(i.e., temperature control, refrigeration/medication storage, availability of running water)

Special safety considerations: ☐ No ☐ 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: ☐ No ☐ 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