FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- Return to Front Office -

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 CONTACT INFORMATION	
PARENT/GUARDIAN NAME (LAST, FIRST)	**RELATIONSHIP TO STUDENT**
PRIMARY PHONE ( )	**SECONDARY PHONE** ( )
EMAIL	
PREFERRED METHOD OF CONTACT : ☐ **PHONE** ☐ **TEXT** ☐ **EMAIL** ☐ **ALL**	
☐ ***ADDRESS IS THE SAME AS ABOVE (IF NOT, PLEASE COMPLETE BELOW FIELDS)***	
ADDRESS (NUMBER, STREET)	**CITY STATE ZIP CODE**

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

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- Return to Front Office -

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

INDIVIDUALS ALLOWED TO CHECK OUT THIS STUDENT				
NAME (FIRST, LAST)	**RELATIONSHIP TO STUDENT:**	**PHONE:**	**LIVES WITH STUDENT?**	**EMERGENCY CONTACT?**
			☐YES ☐NO	☐YES ☐NO
			☐YES ☐NO	☐YES ☐NO
			☐YES ☐NO	☐YES ☐NO
			☐YES ☐NO	☐YES ☐NO
			☐YES ☐NO	☐YES ☐NO

INDIVIDUALS NOT ALLOWED TO CHECK OUT THIS STUDENT *If person not allowed to pick up child is listed on the student's birth certificate, court documentation needs to be provided to the front office.*				
NAME (FIRST, LAST)	**RELATIONSHIP TO STUDENT:**	**PHONE:**	**LIVES WITH STUDENT?**	
			☐YES ☐NO	
			☐YES ☐NO	
			☐YES ☐NO	
			☐YES ☐NO	
			☐YES ☐NO	

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

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- Return to Front Office -

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.

ARRIVE (A.M.)	☐**WALK** ☐**CAR** ☐**SCHOOL BUS**	**DEPART (P.M.)**	☐**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

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 a 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. 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.

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.

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

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- Return to Front Office -

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 (D.O.B.) _____ 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. ☐ Awaiting foster care placement.
   ☐ 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 (brothers or sisters)? ***Note:*** *Use back of page if more space is needed.*

   Name _____ School _____ Grade_____ DOB_____
   Name _____ School _____ Grade_____ DOB_____
   Name _____ School _____ Grade_____ DOB_____

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 ☐ Awaiting Foster Care Placement

Print School Contact | Title | Signature (*required*) | Date | *(Revised 11/2015)*

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- Return to Front Office -

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

ECONOMIC HARDSHIP WAIVER FORM

This form must be completed in its entirety and returned to the school's front office /School Operations Manager as a part of this packet. This form can not be faxed or emailed. Please hand deliver.

FirstLine Schools seeks to balance fairness (i.e., all participating students should pay the same fee) with equity and an acknowledgement of economic hardship families may face at times. As such, School Leaders (or their designee) will offer fee reductions and waivers to students and families who complete the following steps:

1. Make a good faith effort to pay the full fee, including by requesting additional time and/or a payment plan
2. Request a waiver or fee reduction from the School Leader (or designee)
3. Provide additional documentation requested by the School Leader (or designee)
4. Commit to informing the School Leader (or designee) if the family's economic circumstances change and the fee is able to be paid later in the academic year.

The Louisiana Department of Education provides the following examples of a family status that may be grounds to grant a waiver: families receiving unemployment benefits or public assistance, including Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI) or Medicaid; foster families caring for children in foster care; and families that are homeless. School Leaders may use these indicators and other information to make their determination.

School Leaders (or their designee) will communicate the decision regarding a waiver on a rolling basis directly to families. If you have any questions, please do not hesitate to contact your School Operations Manager.

LIST OF FEES

The 2017-18 fees for all FirstLine schools are outlined on the firstlineschools.org website. The list includes the purpose and use of fees, and the amount of each fee.

STUDENT'S LAST NAME	**STUDENT'S FIRST NAME**
ADDRESS (NUMBER, STREET)	**CITY, STATE, ZIP CODE**
PARENT/GUARDIAN NAME	**PHONE NUMBER**

ARE YOU CURRENTLY A RECIPIENT OF ANY OF THE FOLLOWING LOUISIANA PUBLIC ASSISTANCE PROGRAMS? (If so, please select)

- ☐ TANF (Temporary Assistance for Needy Families)
- ☐ SNAP (Supplemental Nutrition Assistance Program)
- ☐ SSI (Supplemental Social Security Income
- ☐ FITAP (LA Family Independence Temporary Assistance Program)
- ☐ Medicaid
- ☐ Homeless
- ☐ Foster Families Living in Foster Care

Please feel free to provide additional documentation

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

FOR SCHOOL USE ONLY **Policy Number:** Fin-1234 (STUDENT FEE HARDSHIP POLICY WAIVER) **Date received** _____ **School Leader or Designee:** _____

- Return to School Nurse -

STATE OF LOUISIANA
HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

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.

Student Name: Last	First	M.I.	Sex: M ❑ F ❑	DOB:	Grade:	School:

Student's Mailing Address:	City:	State:	Zip:

Student's Physical Address:	City:	State:	Zip:

Name of Mother/Legal Guardian	Home Phone	Work Phone	Cell Phone	Employer

Name of Father/Legal Guardian	Home Phone	Work Phone	Cell Phone	Employer

Name of pediatrician/primary care provider	Phone No	Name of medical specialists/clinics	Phone No.

Parents: Please notify the school nurse of any changes in the student's medical condition.

Parent/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 Phone Number Cell 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. **Parents are responsible to keep the school nurse informed regarding their child's health status.**

❑ **ALLERGIES**

Allergy Type:

❑ Food (list food(s) _____ ❑ Medication (list medication(s) _____

❑ Insect sting (list insect(s) _____

❑ Other (list) _____

Reactions- Date of last occurrence:

❑ Coughing Date: _____ ❑ Swelling Date: _____ ❑ Rash Date: _____

❑ Difficulty breathing Date: _____ ❑ Nausea Date: _____ ❑ Other _____

❑ Hives Date: _____ ❑ Wheezing Date: _____ _____

Currently prescribed medications and treatments:
❑Oral antihistamine (Benadryl, etc.) ❑Epi-pen ❑Other _____

❑ASTHMA
Triggers (i.e., tobacco,dust, pets, pollen, etc.) (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 ER visit related to asthma _____

Does your child have a written asthma management plan? ❑No ❑Yes Is peak flow monitoring used? ❑ No ❑ Yes

❑ 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) ❑ Generalized Tonic-Clonic (Grand Mal/Convulsive)
❑ Complex Partial ❑ Other (explain) _____
Physical Education Restrictions: ❑ No ❑ Yes
Medication(s): ❑ No ❑ Yes List medication(s) _____
Date of last seizure _____ Length of seizure _____

❑ OTHER HEALTH CONDITIONS **Chicken Pox: Date of disease:** _____

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

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): _____
_____

❑ VISION CONDITIONS_____ ❑ Contacts/glasses ❑ Other_____
❑ HEARING CONDITIONS_____ ❑ Hearing aid(s) ❑ Other: _____

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

Special adjustments of the school environment or schedule needed? ❑ No ❑Yes (explain):
(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)

_____

_____

Special adjustments to classroom or school facilities needed? ❑ No ❑ Yes (explain)
(i.e., temperature control, refrigeration/medication storage, availability of running water)

_____

_____

Special safety considerations required: ❑ No ❑ Yes (explain):
(i.e., precautions in lifting or positioning, transportation emergency plan, safety equipment, techniques for positioning or feeding)

_____

Special assistance with activities of daily living needed: ❑ No ❑ Yes (explain):
(i.e., *eating, toileting,walking)*

_____

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

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

_____

PART 3: SCHOOL NURSE TO REVIEW if parent/legal guardian indicates medical condition.

Nurse Notes: _____

_____

_____

_____

_____

_____

_____

_____ _____

School Nurse Signature Date

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

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

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

MEDICAL RELEASE FORM	
INSURANCE PROVIDER & GROUP NUMBER	PLAN
PRIMARY INSURED INSURED'S 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