FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

ENROLLMENT PACKET CHECKLIST

FOR SCHOOL USE ONLY

DATE RECEIVED: _____

FIRSTLINE SCHOOL (PLEASE CHECK ONE):

☐ GREEN ☐ ASHE ☐ WHEATLEY ☐ LHA ☐ LIVE OAK

FIRSTLINE SCHOOL ENROLLMENT FORMS CHECKLIST:

☐ General Information and Enrollment (Pages 2-7)
☐ Media Release
☐ Louisiana Student Residency Questionnaire
☐ Economic Hardship Waiver Form
☐ Louisiana Health Information
☐ Medicaid Reimbursement Notice and Consent Form (for Medicaid students only)
☐ Medical Release
☐ Daughters of Charity Consent Form
☐ Communities in Schools Consent Form
☐ Student, Family, and FirstLine Compact

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. ****

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

SIBLINGS ALSO ATTENDING A FIRSTLINE SCHOOL		
NAME (FIRST, LAST)	**FIRSTLINE SCHOOL (GREEN, ASHE, WHEATLEY, LHA, LIVE OAK)**	**GRADE**

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

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- Return to Front Office -

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.

DAY: _____ 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

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- Return to Front Office -

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 of page.***

   If you selected 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. Do 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

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

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 cannot 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 2019-20 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:** _____

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- 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:_____ _____

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- Return to School Nurse -

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

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- Return to School Nurse -

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

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

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- Return to Front Office -

Daughters of Charity Health Centers School Based Health Services Consent Form

Student's Name: Last	First	Middle Initial		ID# (Office use only.)
Student's Address (include city):				Zip Code:
Student's Date of Birth:	Age:	**Sex:** ☐ **M** ☐ **F**	**Race:**	**Ethnicity:**
Student's Social Security Number.		School:		Student's Grade:
Preferred Language:	Student's Email:		Student's Cell Phone: ( )	
Name of Mother (include maiden name) or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Emergency Contact:			Relationship:	Phone: ( )
Emergency Contact:			Relationship:	Phone: ( )
Student's Primary Care Physician:				Phone: ( )
Student's Dentist:				Phone: ( )
Preferred Pharmacy (Name, Street and Phone Number)		Names of siblings enrolled in School-Based Health Center:		

Please check the type of health insurance your child has:

Please send a copy of insurance card (front and back) to DCHC

- ☐ Medicaid/Bayou Health Plan #:_____(check one below)
  - ☐ Amerigroup Real Solutions LA
  - ☐ AmeriHealth Caritas LA
  - ☐ Aetna
  - ☐ LA Healthcare Connections
  - ☐ United Healthcare Community Plan LA
- ☐ Medicaid (dental) #:_____
- ☐ No Insurance
- ☐ **Private/Other Insurance** **Employer Name**:_____
  Employer Address:_____ **Phone #:**_____
  Policy #:_____ **Group #:**_____ **Effective Date:**_____
  Name of policy holder:_____ **Relationship to Student:**_____
  Policy holder date of birth:_____ **Policy holder Social Security #:**_____
  Does your insurance pay for prescriptions? : **No** ☐ **Yes** ☐

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

Is your child allergic to any food or medicine? No ☐ ☐ Yes If yes, list:

List of current medications student is on with dosage (how much) and how often:

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

- Primary and preventive health care
- Laboratory/diagnostic testing
- Behavioral health services
- Referral to specialty care
- Comprehensive history and physical examinations
- Acute care for minor illness and injury
- Referral and follow-up for emergencies
- Health education and prevention programs
- Immunizations
- Management of chronic diseases case management
- Dental services (where available)
- Health screenings

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

HOSPITALIZATION INFORMATION:
Has your child been admitted into a hospital or had surgery: Yes_____ No_____ If Yes. Year: _____
Reason:_____ Hospital_____
Please mark the item(s) that apply to your child's medical history:

____Asthma	____Behavior Problems	____Endocrine (Diabetes, Thyroid, Pituitary)
____Allergy	____Depression	____Infectious Disease (Hepatitis, HIV, TB, Meningitis)
____Tonsillitis	____Substance Abuse	____Missing Organ (Kidney, Eyes, Testicles)
____Seizures	____Anxiety	____Blood Disorder or Birth Defects or Genetic Disorder
____Kidney Disease	____ADHD	____Been Restricted from Sports/FE for Medical Reasons
____Skin Problems	____Heart Disease or Murmur	____Vision Problems
____Chicken Pox	____Ear or Sinus infections	____Other (specify)_____
____Major Injuries	____Hearing and Speech Problems	

Please describe any item marked: _____

FAMILY HISTORY: Please mark the item(s) that apply to your family's history: (B=brothers, S= sisters, P=parents and G=grandparents)

____Cancer	____Depression	____Genetic Disorder	____Tuberculosis
____Asthma	____Substance Abuse	____Sickle Cell	____Stroke
____Seizures	____Anxiety	____Heart Disease/Heart Problem	
____Allergy	____ADHD	____High Blood Pressure	
____Anemia	____Diabetes	____Other (specify)	

Please describe any item marked
(Who/When):_____

I, as parent/guardian, understand that I will not be charged for any of the services provided through the health center. I also understand that Daughters of Charity Health Centers (DCHC) or the physician may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to DCHC.

I also understand that the school based health services are operated by DCHC and its employees and contractors and not with my child's school.

Confidentiality: I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that DCHC has the right to change this notice at any time. I may obtain a current copy by contacting the Administrative Office.

DCHC Statement: I understand that the DCHC may participate in one or more health information exchanges (HIEs), whereby the center may share my health information with other health care providers for treatment, payment or health care operations purposes. I hereby consent to the disclosure of the DCHC's records into the HIEs.

Printed Name of Parent/Legal Guardian	**Relationship (to student)**
Signature of Parent/Legal Guardian	**Date**
Signature of Student	**Date**
Printed Name of School Health Witness/Verify	Position
Signature of School Health Witness/Verify	Date

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

Louisiana state law prohibits health centers in schools from:

1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product.

FIRSTLINE SCHOOLS: **RETURNING STUDENT** ENROLLMENT PACKET

- Return to Front Office -

Parent and Student Consent Form

I give permission for my son/daughter: _____ to participate in programs sponsored by Communities In Schools of Greater New Orleans, Inc. (CIS) at

I understand that my permission is being given so that:

- My child can receive services provided or coordinated by Communities In Schools staff, service providers and/or volunteers. The services may include but are not limited to supportive guidance/counseling, educational support, tutoring, mentoring, enrichment activities, testing, and referrals to other agencies as needed. I have received information about the services by CIS.
- I understand that CIS staff, service providers or volunteers can obtain confidential information, which may include information from, school records, financial information, public assistance status, test scores, medical information and questionnaires.
- I understand that the information collected on the CIS forms is maintained in a secure computer database and a case file. This information is used by CIS to document services provided to students and families to evaluate the CIS program. I also understand that CIS may use the information to verify CIS participants, update service information, and provide closure and follow-up information. I authorize CIS to maintain the information provided for the purposes noted above in the CIS computer database and case file.
- My child can participate in field trips and other activities sponsored by CIS. Private transportation may be used in these and other activities.

In the event of the need for emergency medical care, CIS will follow the procedures of your child's school.

- There will be direct interaction between my child and CIS staff and volunteers and staff of CIS partnering agencies.
- Participation in interviews, tests, and surveys for student or program evaluation.

I release Communities In Schools of New Orleans, Inc. and its employees, volunteers, or agents from liability for accidents injuries, or illnesses that may occur to my child during his/her participation in the program.

My child and I understand that we are voluntarily participating in the Communities In Schools of New Orleans, Inc. program. This consent remains in effect until revoked by me in writing and given to the CIS Site Coordinator.

Parent/Guardian Name (Please print): _____

Address: _____ **City:** _____ **Zip:** _____

Telephone Numbers: (Home) _____ **(Work)** _____ **(Cell)** _____

Email Address: _____

May we use photographs or audio/ video picture(s) of my child for program purposes? YES q NO

Parent/Guardian Signature: _____ **Date:** _____

Student's Name (Please Print): _____ **Student's Signature:** _____

Grade: _____ **Gender:** _____ **Male** _____ **Female** **Date of Birth (mm/dd/yy):** _____

Ethnicity (check one): _____ **African-American** _____**White** _____**Asian** _____**Hispanic**

_____ **Multiracial** _____**Native American** _____**Other, Please Specify:** _____

Does your child currently qualify for free or reduced lunch at school?

_____**Free Lunch** _____**Reduced Lunch** _____**Neither, he/she pays full price for lunch**

CIS Staff Signature: _____ **Date PC Received:** _____

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

STUDENT, FAMILY, AND FIRSTLINE COMPACT

As a student at a FirstLine school I agree to:

- Do my best to live the school values.
- Make the school a safe environment so my classmates and I can succeed academically.
- Arrive on time every day.
- Come to school prepared and ready to do whatever it takes to accomplish my goals.
- Do my best work every day, even when it is hard.
- Do the right thing, even when no one is looking.
- Be respectful to my classmates, my teachers, and other members of the school community.
- Do my homework every day.
- Ask for help when I need it.
- Promptly give my parent or guardian all notices and information from the school.
- Be accountable and accept responsibility for my actions.

As a parent or guardian of a student(s) at a FirstLine school I agree to:

- Do whatever it takes to help my student reach his or her goals.
- Make sure my student arrives at school on time every day.
- Help my student complete his or her homework each night.
- Support and encourage my student to read at home for fun.
- Ensure my student is getting at least eight hours of sleep each night.
- Monitor and take responsibility for how my student uses the internet and social media.
- Get involved at school by volunteering in the classroom, at school events, on field trips or by joining our parent organization.
- Participate in decisions relating to my student's education.
- Support my student's participation in extracurricular activities and school events.
- Promptly read all notices sent home with my student and respond as appropriate.

As a FirstLine school our team will:

- Provide high-quality curriculum and instruction in a supportive environment.
- Set clear expectations for academics and behavior.
- Provide regular reports of your student's academic progress through progress reports, report cards, and state test results.
- Hold regular family-teacher conferences.
- Communicate respectfully about your student's behavior.
- Ensure our staff respond to you within 24 hours and are available by phone until 8:00 pm and in person during conference hours.
- Provide families opportunities to get involved.
- Provide families adequate notice of school events, field trips, and important information.
- Support your student's academic goals.
- Provide personalized academic and emotional support to struggling students.

I acknowledge that I have reviewed the items above, and agree to all items in the compact for the 2020-2021 academic year.

PARENT/GUARDIAN NAME (FIRST, LAST) SIGNATURE DATE