YOU WILL NEED THE FOLLOWING PAPERWORK FOR ENROLLMENT:

1. **BIRTH CERTIFICATE**
2. **SHOT RECORDS**
3. **SOCIAL SECURITY CARD**
4. **CUSTODY PAPERS**
5. **SPECIAL EDUCATION RECORDS**
   (if applicable)
6. **LAST GRADE CARD**
7. **PROOF OF RESIDENCE**

You may use the following documents for proof of residence –

1. A deed, mortgage, lease, current homeowner's or renter's insurance declaration page, or current real estate property tax bill
2. A utility bill or receipt of utility installation issued within ninety days of enrollment
3. A paycheck or paystub issued to the parent or student that includes the address of the parent's or student's primary residence
4. The most recent available bank statement issued to the parent or student that includes the address of the parent's or student's primary residence
5. Any other official document issued to the parent or student that includes the address of the parent's or student's primary residence. The superintendent of public instruction shall develop guidelines for determining what qualifies as an official document under this division

OHIO SCHOOL LAW

In order to facilitate the enforcement of the Missing Child Law, the law requires each entering student to provide, a certified copy of any child custody order or decree which has been issued with respect to the student. The custodial parent of such a student must also provide the school with certified copies of any later court orders which modify the original custody order or decree.

COSHOCTON OPPORTUNITY SCHOOL REGISTRATION FORM 24-25 School year

Information supplied on this form is required under provisions of Ohio Law and the Ohio Department of Education.
It is in no way an effort to trespass upon the personal affairs of parents. Your cooperation in completing this form is appreciated.

PLEASE PRINT – PARENT/GUARDIAN SHOULD COMPLETE ALL INFORMATION.

1. STUDENT DATA

Grade student will be entering ________

Has student ever attended Coshocton City Schools? Yes____ No____ If YES: School ______________
Grade(s) Enrolled ____________

Student Name (LEGAL NAME AS IT APPEARS ON BIRTH CERTIFICATE) :

____ Last Name Suffix (Jr., III, etc)__________
First Middle Last

Gender (circle one) **F** or **M**

Social Security #____________________________

County of Residence (circle one): Coshocton, Knox, Holmes, Licking, Muskingum

Home Phone: Area Code _______ ---_______________ Unlisted? Yes___ No___

Street Address____

P.O. Box #__________ City______________________ Zip___________

STUDENT'S BIRTH DATA

Date of Birth: Month__________ Day_________ Year________ Mother's Maiden Name____________________

Birth City____________________ State ________ If child was born outside U.S., list country______________

Citizenship of student: ____USA Other ______________ (specify country)

Native Language spoken in home: ____English Other______________ (specify language)

If child was born outside the U.S., how many years has he/she been attending a U.S. school? ______________

2. RACIAL / ETHNIC DATA

PLEASE ANSWER BOTH A AND B

A. Is the student Hispanic/Latino?
(Hispanic/Latino means a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

____ Yes ____ No **(go to part B)**

B. Is the student: (check all that apply)

____ **American Indian or Alaska Native** (Persons having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.)

____ **Asian** (Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

____ **Black or African American** (Persons having origins in any of the black racial groups in Africa.)

____ **Native Hawaiian or Pacific Islander** (Persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

____ **White** (Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.)

(If left blank, ethnicity will be determined by observer identification)

Coshocton City Schools is mandated by the United States Department of Education, under the No Child Left Behind Act, to collect and report this information for all students who enroll in the school district.

3. PREVIOUS SCHOOL INFORMATION

- **Does your child have an IEP or 504 plan or has he/she received special education services in the past?**

  Yes___ No___
  (If yes, provide a current copy of IEP and ETR.)

- **Is student under expulsion from previous school?**

  Yes___ No___

- **School where child was most recently enrolled:**

District______________________________

School______________________________

School Address________________________

Phone #______________________________

Fax #________________________________

PLEASE COMPLETE REVERSE SIDE →

PLEASE COMPLETE REVERSE SIDE →

COSHOCTON OPPORTUNITY SCHOOL REGISTRATION FORM

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PLEASE PRINT – PARENT/GUARDIAN SHOULD COMPLETE ALL INFORMATION

Student Name ______________________________ Grade ________

4. FAMILY & CUSTODIAL DATA

- **Status of Biological Parents:** ____Parents Married ____Parents never Married ____Parents Separated ____Parents Divorced ____Father Deceased ____Mother Deceased
- **Who has legal custody of this student?** ______________________________

If a divorce or guardianship situation exists, we must have a certified full copy of the order of decree. This is per State of Ohio Law (ORC 3313.672) and the Missing Children's Act.

- **Student lives with:** ____ Mother & Father ____ Mother only ____Mother & Stepfather ____ Father only ____ Father & Stepmother ____Foster Parent ____Host parent ____Court appointed Guardians/Grandparents ____ Other

INFORMATION for Mother /Guardian/ Foster Parent (circle one)

Name ______________________________
First M.I. Last

Home address ______________________________
Street Address City State Zip

Home Phone: ______________ Cell Phone ______________

Employer ______________ Work phone ______________

Email address: ______________________________

INFORMATION for Father /Guardian/ Foster Parent(circle one)

Name ______________________________
First M.I. Last

Home address ______________________________
Street Address City State Zip

Home Phone: ______________ Cell Phone ______________

Employer ______________ Work phone ______________

Email address: ______________________________

INFORMATION for Step-Mother /Step-Father (circle one)

Name ______________________________
First M.I. Last

Home address ______________________________
Street Address City State Zip

Home Phone: ______________ Cell Phone ______________

BROTHERS AND SISTERS

Name	Age	Grade

OFFICE STAFF

HAVE YOU COLLECTED?

Legal Birth Certificate	Y	N
Proof of Residency	Y	N
Immunization Record	Y	N
Social Security Card	Y	N
Legal Custody Documents	Y	N
Court/Foster Placement Form	Y	N
Copy of IEP, if applicable	Y	N

5. PARENT / GUARDIAN SIGNATURE

I, the undersigned, state that I am the parent or legal guardian of the above named student and that the registration information provided is true and correct.

Signature of
Parent/Legal Guardian: X ______________________________ Date: X ______________

COSHOCTON OPPORTUNITY SCHOOL
EMERGENCY MEDICAL AUTHORIZATION

Student Name: ______________________ Telephone #: ______________

Student Address: ____

Street City State Zip

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

Residential Parent or Guardian

Mother's Name ______________________ Contact Phone # ______________

Father's Name ______________________ Contact Phone # ______________

Other Contact ______________________ Contact Phone # ______________

Name of Relative Living Closest To You ______________________________

Relationship ______________________ Contact Phone # ______________

Address ____

Street City State Zip

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospitals to be called:

Doctor ______________________ Phone ______________

Dentist ______________________ Phone ______________

Medical Specialist ______________________ Phone ______________

Local Hospital ______________________ Emergency Room Phone ______________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

____

____

____

Signature of Parent ______________________ Date ______________

PART II – REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following actions:

____

____

Signature of Parent ______________________ Date ______________

8-2006

ANNUAL MEDICAL UPDATE
2024-2025

STUDENT NAME   DATE OF BIRTH   BUILDING   GRADE & TEACHER

I. HEALTH CONDITIONS – Please, check any that this student has had: **DATE OF LAST EXAM: PHYSICAL** _____________ **DENTAL** ___________

_____Abnormal spinal curvature (scoliosis, etc.)
_____Allergies or hay fever (list below in section IV)
_____Anemia
_____Arthritis
_____Asthma
_____Behavior problems
_____Birth or congenital malformation
_____Cancer, Type_____________________
_____Chicken Pox
_____Concern about siblings/friend relationship
_____Cystic Fibrosis
_____Diabetes
_____Diarrhea, or Constipation
_____Eczema
_____Emotional Problems
_____Headaches (frequent)
_____Heart Disease
_____Hepatitis
_____Kidney Disease
_____Measles (10 day)
_____Meningitis or Encephalitis
_____Mumps
_____Rheumatic Fever
_____Rubella (3 day measles)
_____Seizures/epilepsy
_____Sickle Cell disease
_____Skin rashes (frequent)
_____Stool soiling
_____Throat infections (frequent)
_____Tics/nervous twitches
_____Tuberculosis or + TB
_____Urinary Tract Infections
_____Wetting (daytime/night)

Please comment, as you feel necessary, on any of the above (more space provided on back of page):____

II. VISION AND HEARING

Frequent ear infections?__________Which ear?_____________How often?______________________
Reduction in hearing?____________When?_______________ P.E. Tubes?_____________________In place?___________
Wears glasses/contacts (circle)? Reason? (circle) Distance Close-up Other-explain ______________________

III. INJURIES/ILLNESSES/SURGERIES– Please list any surgeries, severe injuries or illnesses:

Injuries/Illnesses/Surgery	Age	Hospitalized/Treatment

Comments (more space provided on back of page):____

IV. ADDITIONAL INFORMATION

DAILY medication, dosage, condition being treated:	MEDICATION or ENVIRONMENTAL ALLERGIES:
Medications taken frequently but not daily & reason:	

Signing below gives your permission for the school nurse to contact your child's physician concerning any health care concerns and for this information to be shared with school staff as needed to care for your child during the 2015/2016 school year.

COMPLETED BY:_______________________ RELATIONSHIP TO STUDENT:___________________DATE:__________

4/16/15

Please attach any other relevant medical information, if necessary. Addition comments concerning health issues, medications & concerns: ___________