REGISTRATION INSTRUCTIONS

STUDENTS WILL NOT BE ENROLLED UNTIL REQUIREMENTS ARE MET AND PAPERWORK IS COMPLETE.

DOCUMENTS AND INFORMATION NEEDED FOR ENROLLMENT:

1. Student's original Birth Certificate or Passport.

2. Copy of the driver's license of the student's parent/legal custodian (for photo identification purposes).

3. Proof of residency (see other side for requirement details). If your residency changes, inform the school district and provide the required proof. Please be aware that the school district has the right to investigate residency and act accordingly.

4. Custody: When applicable, the custodial parent/legal guardian must provide the certified/court stamped copy of the custody order or decree which shows that he/she is the "residential" custodian or legal guardian. Please bring the entire document. Also, a marriage license may be required in some circumstances. Students are eligible to attend school in the district where the custodial parent, or legal guardian, resides.

5. In the event a biological parent is deceased, provide a copy of the death certificate.

6. Proof of immunizations.

IMPORTANT

If your child currently receives special services (has an I.E.P. - Individual Education Plan - or Section 504 Plan), please bring your copy with you at time of registration.

NOTE: Although a registration may be for a former Oak Hills student, we follow the entire procedure as if it is a new registration. Please provide the required documents.

Thank you for your cooperation. For questions, please call District Office at 513-574-3200.

PROOF OF RESIDENCY

NOTE: REGISTRATION WILL NOT BE ACCEPTED UNTIL ALL REQUIREMENTS ARE MET.

This also applies to an address change for current students. You are required to inform the school district of any change. The school district has the right to investigate residency.

ACCEPTABLE PROOF OF RESIDENCY:

1. Copy of deed, current mortgage information, current 1098 form, recent settlement statement, or the most recent property tax bill (no print-outs from the auditor's website please). OR

2. Current rental or lease agreement: provide full document, signed and dated. It must contain the **NAME, ADDRESS, AND CONTACT NUMBER OF THE LANDLORD.** OR

3. Parent(s) and student(s) living with another person: Parent must obtain affidavits from the Oak Hills District Office at 6325 Rapid Run Road PRIOR to registration. Please contact Donna Bella at 574-3200. The affidavits must be fully completed, notarized, and provide the required **attachments**. This only applies if the current occupant is the homeowner. If moving in with someone who is a renter (sharing an apartment or rented house) you need to have your name added to the rental agreement, or have the landlord/apt. manager provide an addendum to the current lease or rental agreement indicating you and your family also live there.

House Under Construction/Purchase:

If a person has a contract to build, parent(s) must submit, at registration, a copy of the **contract, PLUS** a letter from the builder stating that he does have a firm contract and giving an estimate of the time of completion (not to exceed 90 days from the day school starts or from the time the child starts school). The letter should contain the builder's name, address and phone number. **After closing, the school must receive a copy of the settlement statement or mortgage papers or deed within 10 days.**

If a person has a signed a contract to purchase a home, a copy of the purchase agreement along with a closing date must be submitted at time of registration. The occupancy date must be within 60 days from the day school starts or the first day the child attends school. **After closing, a copy of the settlement statement must be submitted to school within 10 days.**

RE: Students currently enrolled only – we will accept a current Duke or utility bill to "change" an address.

If you have any questions, please contact Donna Bella at 574-3200.

Revised 5/15/15

STUDENT REGISTRATION – OAK HILLS LOCAL SCHOOL DISTRICT

STUDENT ID # _____

PLEASE PRINT FRONT AND BACK CUSTODIAL PARENT MUST COMPLETE THIS FORM

STUDENT'S NAME (Last) _____ (First) _____ (Middle) _____

(Name must be as it appears on birth certificate)

Is Student called by first Name? ☐ Yes ☐ No If not: _____

Student's Date of Birth: Month _____ Day _____ Year _____ Location of Birth: City _____ State _____

Grade _____ ☐ Male ☐ Female Current Age: _____

ADDRESS _____ City _____ ST _____ Zip _____

Home Phone _____ PREVIOUS ADDRESS (within 5 years) _____

Mother's Cell Phone Number _____ Mother's E-Mail Address _____

Father's Cell Phone Number _____ Father's E-Mail Address _____

Brothers' Names _____ Age(s) _____ School(s) _____

Sisters' Names _____ Age(s) _____ School(s) _____

STUDENT'S RACE AND ETHNICITY

Is the student Hispanic, Latino or of Spanish origin (regardless of race)? ☐ Yes ☐ No

Note: Hispanic or Latino means a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

What race is the student (Choose all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Pacific Islander ☐ White

If you choose not to indicate your child's race, the Oak Hills Local School District is required by Federal law, to identify your child by observation

PARENT/LEGAL CUSTODIAN INFORMATION

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Remarried ☐ Widowed ☐ Court Order**

Name and relationship of custodial parent(s): _____

**Evidence of legal custody must be presented and filed with the school.

MOTHER'S NAME: _____ Maiden Name _____

Is mother living? ☐ Yes ☐ No Mother's Date of Birth _____ Does student live with mother? ☐ Yes ☐ No

Address (if not same as student's) _____ City _____ ST _____ Zip _____

Place of employment _____ Occupation _____ Work No. _____

If remarried, husband's name _____ Phone No. _____

FATHER'S NAME: _____

Is father living? ☐ Yes ☐ No Father's Date of Birth _____ Does student live with father? ☐ Yes ☐ No

Address (if not same as student's) _____ City _____ ST _____ Zip _____

Place of employment _____ Occupation _____ Work No. _____

If remarried, wife's name _____ Phone No. _____

LEGAL CUSTODIAN (if different than above): _____ Relationship: _____

Contact numbers: Home: _____ Cell: _____ Work: _____

MILITARY STATUS

Please select the option that best describes your family's military status:

☐ Active Duty: student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marines or Coast Guard)
☐ National Guard: student is a dependent of a member of the National Guard (Army or Air)
☐ Reserve Duty
☐ Not Applicable

OCCUPATIONAL SURVEY

Has anyone in your immediate family been involved in one of the following occupations, whether full time or part-time or temporarily during the last 36 months? ☐ Yes ☐ No

Agriculture: planting/picking of fruits or vegetables

Packing/Canning: fruits or vegetables

Meat or seafood packing/meat or seafood processing

Fishing or fish farms

Nursery work: preparing soil, planting seedlings or other activities related to the production of flowers and/or other greenhouse commodities OR timber work: planting, growing or cutting trees

Dairy/Poultry/Livestock

EDUCATIONAL BACKGROUND

Has this student attended any Oak Hills School prior to this enrollment (including an OHLSD preschool?) ☐ Yes ☐ No

If Yes: Date: _____ School(s) _____ Grade(s) _____

NAME OF LAST SCHOOL ATTENDED _____

Address of former school _____ City _____ State _____ Zip _____

Is student currently expelled? ☐ No ☐ Yes If yes, what dates _____

IEP – Individual Education Plan

Is the student on an IEP (Individual Education Plan) and currently receiving special education services? ☐ Yes ☐ No

Disability Category:

☐ Specific Learning Disability ☐ Orthopedically/Health ☐ Emotional Disturbance
☐ OHI (Other Health Impaired) ☐ Intellectual Disability ☐ Speech/Language Impaired
☐ Traumatic Brain Injury ☐ Autism ☐ Visually Impaired
☐ Multiple Disabilities ☐ Hearing Impaired ☐ Deaf/Blindness

SECTION 504 PLAN: Is the student on a 504 Plan and currently receiving educational services? ☐ Yes ☐ No

Retention: Has your student ever been retained? ☐ Yes ☐ No If yes, what grade? _____

Is student enrolled in a Gifted Program? ☐ Yes ☐ No

IF PARENTS CANNOT BE REACHED, WHO SHOULD BE CALLED

Name: _____ Relationship: _____ Phone No. _____

Name: _____ Relationship: _____ Phone No. _____

Family Physician _____ Phone No. _____

Is the student on any medication? ☐ Yes ☐ No If yes, name _____

Does the student have any of the following conditions: ☐ Diabetes ☐ Epilepsy ☐ Asthma ☐ Bleeder ☐ Heart Condition

Allergy (Specify) _____ Other: _____

My signature below certifies that I am a current resident of the Oak Hills Local School District and that I have supplied the school district with the proper proof of residency. I agree to immediately inform the school district if my residence changes. I understand that the school district has the right to investigate my claims of residency and act accordingly. The information on this form is true and accurate to the best of my knowledge.

_____ _____ _____
Signature of Parent or Legal Custodian Date Phone

_____
Printed Name

COMPLETING AND RETURNING THIS FORM TO A SCHOOL BUILDING DOES NOT GUARANTEE PLACEMENT AT THAT SCHOOL.

Ohio | Department of Education

Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

Student Name: *(First Name and Last Name)*	**Student Date of Birth:** *(mm/dd/yyyy)*

Communication Preferences Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.	1. In what language(s) would your family prefer to communicate with the school? _____
Language Background Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.	2. What language did your child learn first? _____ 3. What language does your child use the most at home? _____ 4. What languages are used in your home? _____
Prior Education Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.	5. In what country was your child born? _____ 6. Has your child ever received formal education outside of the United States? ⌋ Yes ∆ No If yes, how many years/months? _____ If yes, what was the language of instruction? _____ 7. Has your child attended school in the United States? ∆ Yes ∆ No If yes, when did your child first attend a school in the United States? _____ /_____/ _____ Month Day Year
Additional Information Please share additional information to help us understand your child's language experiences and educational background.	

Parent/Guardian First Name:_____ Parent/Guardian Last Name: _____

Parent/Guardian Signature:_____ Today's Date: *(mm/dd/yyyy)* _____

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: https://www2.ed.gov/about/offices/list/ocr/ellresources.html

Pre-Kindergarten Experience Survey

Dear Parent/Guardian: We are requesting that families complete and return the survey below. Your responses to this survey will help us learn more about your child's diverse early learning experiences. All the information on this survey will be kept secure and confidential. Thank you in advance for your assistance.

Child's First Name: _____ Last Name: _____

Date of Birth _____ Gender: ☐ Male ☐ Female

Home School: ☐ CO Harrison ☐ Delshire ☐ J.F. Dulles ☐ Oakdale ☐ Springmyer

Does your child qualify for free/reduced lunch or any other government assistance program? ☐ Yes ☐ No

Primary language spoken at home: ☐ English ☐ Spanish Other: _____

From the age of 3 until the time he/she entered Kindergarten…

1. Did your child attend a part-day preschool or childcare program?
   ☐ Never ☐ 1 year or less ☐ more than 1 year

2. Did your child attend a full-day preschool or childcare program?
   ☐ Never ☐ 1 year or less ☐ more than 1 year
3. Did your child participate in a Head Start program?
   ☐ Never ☐ 1 year or less ☐ more than 1 year
4. What is the name of the preschool, Head Start, or child care program your child attended the longest?
   _____
5. How many times have you moved before your child entered kindergarten?
   ☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 or more times

Parent Signature _____ Date: _____
Parent Printed Name: _____
Parent Phone Numbers: _____ _____
Parent Email: _____

OAK HILLS LOCAL SCHOOL DISTRICT
6325 RAPID RUN ROAD
CINCINNATI, OHIO 45233

Instructions to Parents Filling Out "School Health Examination Record"

Complete forms and give as much information as possible.

****The State of Ohio Compulsory Immunization Law states that all children who enter Ohio Schools **MUST** have received the following immunizations:

a. 5 doses of DPT (Diptheria, Pertussis and Tetanus) for Kindergarten
   1 dose of Tdap or Td vaccine on entry to 7th grade

b. 4 doses of Polio Vaccine (OPV/IPV)

c. 2 doses of Rubeola, Rubella, and Mumps (MMR) must be administered after 12 months of age.

d. 3 doses of Hepatitis B Vaccine

e. 2 dose Varicella Vaccine must be administered prior to entry of kindergarten.

NOTE: Your child **MAY NOT ENTER** school unless he/she has received the above listed immunizations. The attached form **must be completed** by your physician and returned to your child's school by July 31. The oral assessment/Dental form is highly recommended but is not a requirement.

Revised 1/2012

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments
_____
_____
_____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL

Tuberculin Test

Date_____ Type _____ Results_____

Health History (Serious or chronic illnesses/injuries/surgeries)

_____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

_____

_____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

_____

_____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

_____

_____

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4242 8/06

Ohio Department of Health • School and Adolescent Health

Immunization Report

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).
A copy of the child's immunization record may be attached or dates may be entered below.
Please note the month, day, and year for each immunization should be on record.

Vaccine	**Record complete dates** (month, day, year) **of vaccine doses given**					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other _____

Signature	Print name	Date
		/ /

HEA 4241 8/06

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth
	/ /

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)
☐ Other_____

The following oral hygiene instruction was provided (please check all that apply)

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouthrinse
☐ Other_____

The following statements are applicable (please check all that apply)

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated.(See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.

Comments

Dentist's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP