LEMAN ACADEMY of EXCELLENCE

STUDENT REGISTRATION MAIL-IN FORMS COVER LETTER

Student Name: _____ Date of Birth: ___/___/___ Grade Level: _____
Last, First, Middle

Parent/Guardian Name: _____ Phone: (____) _____
Last, First

Address: _____
Street, City, State, Zip

MAIL-IN FORMS CHECK LIST

*Note: Forms can also be handed in at school.

- ☐ Emergency, Information and Immunization Record Card
- ☐ Permission Form: Administering Prescription Medication at School **OPTIONAL
- ☐ Over-The-Counter Medication Form (2016-2017 School Year) **OPTIONAL
- ☐ Authorization for Release Form
- ☐ Proof of Arizona Residency Form & Documentation (must match physical address)
- ☐ Verification of Student Date of Birth Form & Documentation
- ☐ Student Photography Release and Internet Usage Form
- ☐ Primary Home Language Other Than English (PHLOTE) Home Language Survey
- ☐ 2016-2017 Full-Day Kindergarten Registration/Payment Form (if applicable)

- ☐ Copy of Immunization Records
- ☐ Copy of Parent Photo ID
- ☐ Withdrawal Form from Previous School (Not necessary for Preschool or Home School students. To be requested at the time of withdrawal or completion of the school year.)

Additional documents to be submitted ONLY if applicable to your child.

- ☐ Individual Education Plan (IEP)
- ☐ Legal Custody Papers
- ☐ 2016-2017 Full-Day Kindergarten Registration/Payment Form
- ☐ Home School Records

IMPORTANT
All forms must be filled out in full, signed, and submitted to the school by the child's parent or legal guardian.

All of the above forms can be handed in at school or mailed/faxed to the following (health forms are to be handed in, mailed, or faxed as an added measure of safety to secure the privacy of personal health information per HIPAA):

Leman Academy of Excellence
7720 N Silverbell Rd, Bldg 1 & 2
Tucson, AZ 85743

Fax: (520) 395-1352

HEALTH SERVICE GUIDELINES

We recognize the role that a child's health plays in his/her ability to learn. We want to work with you to support the growth and development of your child in the school setting. Leman Academy employs a full-time Registered Nurse in order to ensure that the best care for your child's health in the school setting is being maintained. The Health Office is open during school hours and may be contacted by calling the school at (520) 639-8080 ext 1136.

Please contact the school nurse for any health concerns related to your child. Your student's nurse will work with you and your child's physician to develop a plan of care. This written plan is shared with your child's teacher(s) and will help coordinate care for your child's health condition during the school day.

Please remember the school nurse is not a substitute for proper medical care and cannot diagnose or prescribe for your child. The school nurse must follow all State Scope of Practice regulations. As such, the law prohibits the school nurse from dispensing medication of any kind, including over-the-counter medication such as Tylenol, without a written order from a physician and parent.

The health office will carry a limited amount of Tylenol, Motrin, Benadryl, antacid, and cough drops. Students will need an appropriate consent form from the office, signed by the physician and parent, in order to receive these over-the-counter medications.

PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS

When it is necessary for a student to receive medication during the school day, the following procedure has been established to ensure protection of the students and school:

- The parent/legal guardian must provide written permission, including physician and parent signature, for school staff to administer medication to the student. Appropriate forms are available from the school office.
- All medications are to be taken to the Health Office by an adult, not the student.
- The prescription medication must come to the school in the original labeled container with the student's name on it.
- Parents can request two containers – one for the school and one to keep at home. The health office cannot accept medication from a baggie, foil, or envelope that is transferred into a prescription bottle.
- Expired medications cannot be accepted.
- A new medication consent form must be provided for any changes in medication including dosage and time to be given.
- Medical provider orders and prescription bottle directions must match. An order to change the dose may be faxed to the school by the medical provider for short-term administration. A new bottle should be provided to the school as soon as possible. Parents are not allowed to vary school dosage without written medical provider orders.

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HEALTH SERVICE GUIDELINES

- Medications will be kept locked in the health office. Students may not carry or administer their own medications except with special written permission from the school. This includes prescription and over-the-counter medications such as cough drops.
- Students who need to carry and/or self-administer certain medications for life threatening conditions must have written permission from the school and the physician. Students and parents should meet with the school nurse to evaluate the student and to discuss the expectations associated with allowing a student to self-carry and/or self-administer medications.
- Each dose of medication given to a student will be documented in the Student Health Record.
- Narcotic pain medication is discouraged. These medications cause extreme drowsiness and may decrease the child's ability to focus and learn. They are also controlled substances and require heightened security. Some common prescriptions include Tylenol with Codeine, Percocet, Vicodin, or any medication that contains morphine, codeine, hydrocodone, or oxycodone. Parents need to speak with the school nurse if a narcotic needs to be administered.

ILLNESS

The Leman Academy follows health guidelines established from the Pima County Public Health Department. Please take a moment to review the following health issues listed below and the guidelines we will follow:

Fever

- A temperature of **101** will be sent home from school.
- The student may return to school when he/she is fever free for 24 hours without the use of fever-reducing agents such as Tylenol or Motrin.

Vomiting/Diarrhea

- A student with vomiting or diarrhea will need to be sent home.
- Vomiting and diarrhea are typically caused by a virus or bacteria that can be very contagious to others.
- The student may return to school when it has been over 24 hours from the last episode of vomiting/diarrhea.

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HEALTH SERVICE GUIDELINES

Pink Eye

- A student with possible pink eye will be sent home.
- The student may return to school once symptoms have cleared.
- OR a physician writes a note stating that the student is not contagious.
- OR the student has received antibiotics for 24 hours.

Strep Throat

- A student diagnosed with strep-throat may return to school 24 hours after antibiotics have been started.
- AND when fever free for 24 hours without use of fever-reducing medication.

Rashes

- A student with an unidentified rash may have a communicable disease that could be contagious to other students.
- A student will be sent home until the rash has cleared up.
- OR a Physician writes a note stating that the student is not contagious.

SURGERY, MAJOR ILLNESS, OR ACCIDENT

Should your child have surgery, major illness, or an accident please contact the school nurse so that we may assist you with safe and appropriate care for your child's return to class.

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CDC/SGH# or name:_____

Arizona Department of Health Services
Bureau of Child Care Licensing

Emergency, Information and Immunization Record Card

Child's Name:	**Date Enrolled:**	Updated:
Home Address (#, Street, City, State, Zip Code):		**Date Disenrolled:**
Home Phone:	**Date of Birth**:	**Sex:** ☐ **male** ☐ **female**

Mother or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

Father or Guardian Name:	**Home Address (#, Street, City, State, Zip Code):**
Cell Phone (optional):	**Contact Telephone Number:**

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)

Name:	**Contact Telephone Number**:
Name:	**Contact Telephone Number**:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	**Name**:	**Contact Telephone Number**:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

In case of injury or sudden illness, I request that this individual be called first:	

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. ☐ yes ☐ no

Telephone Authorization Code (optional):_____

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:
www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

☐	Copy of current official documented immunization record attached
☐	Religious Beliefs exemption form signed by parent/guardian attached
☐	Medical Exemption form signed by physician and parent/guardian attached
☐	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

Is child allergic to food or other substances? ☐ **No** ☐ **Yes** **If yes**, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	
Is child usually susceptible to infections and if so, what precautions need to be taken? ☐ **No** ☐ **Yes** **If yes**, list precautions:	
Is child subject to convulsions and what should be our procedure if one occurs? ☐ **No** ☐ **Yes** **If yes**, specify procedure:	
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? ☐ **No** ☐ **Yes** **If yes**, list precautions:	
Additional comments:	
Other special instructions:	

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	**SIGNED Name**:	**DATE:**

LEMAN ACADEMY
of EXCELLENCE

Health Office

OPTIONAL

PERMISSION FORM
ADMINISTERING PRESCRIPTION MEDICATION AT SCHOOL

Note: This form is valid for the 2016-2017 school year.

Student Full Name: _____ DOB: _____

Allergies: _____ Weight: _____ lbs

The healthcare provider must complete the information required below. Medication must be delivered to school in the original container with the label intact and includes the student name. The medication is to be given in the following manner:

Name of Medication: _____

Strength of Medication: _____

Amount to be given: _____

Time of Administration at School: _____

Route of Administration (by mouth, etc.): _____

Instructions and/or Comments: _____

Reason for Medication: _____

Date Medication is to be discontinued: _____

Prescription Number: _____ Expiration Date: _____

☐ **Refer to Pharmacy Prepared Label on Medication vial for Healthcare Provider signature, or see below:**

_____ _____
Healthcare Provider Name (Print) Phone

_____ _____
Healthcare Provider Signature Date

I hereby request and give my consent for the School Nurse or other school personnel designated by the Principal to administer the medication indicated above. I give the school nurse permission to discuss my child's medication with the above named Physician. I understand it is my responsibility to provide the medication, and that it be presented to the school by an adult. I understand that it is my responsibility to notify the school immediately if there are any changes in medication, and that a new form must be completed. The school shall not be held responsible for missed or refused doses or side effects caused by the medication. In return for the school's assistance in administering the medication, I hereby waive any claim for injury against the school, or it's employees, arising from the medication administration. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

_____ _____
Parent/Guardian Name (Print) Date

_____
Parent/Guardian Signature

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LEMAN ACADEMY
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Health Office

****OPTIONAL****

OVER-THE-COUNTER MEDICATION FORM (2016-2017 SCHOOL YEAR)

Over-the-counter Medications available at Leman Academy with Physician Order

Student Full Name: _____ DOB: _____

Allergies: _____ Weight: _____ lbs

Medication: **BENEDRYL or generic equivalent**
Strength: Elixir 12.5mg/5ml
Route: Oral

This form will not be accepted without a Physician's signature.

Indication for use: MILD allergic symptoms from a single system area including a few hives or allergic rash, itchy mouth, itchy nose, sneezing, mild nausea or gastric discomfort appearing during school hours, with NO OTHER SYMPTOMS.

DOSAGE

Between 38-49lbs:	1½ teaspoons (18.75mg)
Between 50-99lbs:	2 teaspoons (25 mg)
Above 100lbs:	4 teaspoons (50mg)

FREQUENCY

May repeat every 4 to 6 hours, not to exceed more than 6 doses in 24 hours. Over-the-counter medications will not be given for more than three consecutive days without an updated order from a physician. To ensure that the use of this medication is not masking symptoms or any serious condition, a Physician's Order must be submitted to the school for administration of non-prescription medications beyond the recommended product label instructions.

Procedure: Call parents or legal guardian. Monitor student closely until symptoms resolve. If symptoms worsen, or for symptoms from more than one system area, administer Epinephrine if available and call 911.

Additional Instructions: _____

Parent/Legal Guardian Name

Print: _____

Signature: _____

Date: _____

Healthcare Provider Name

Print: _____

Signature: _____

Date: _____ Phone: _____

Medication: **Tylenol or Generic Equivalent**
Strength: 160mg chewable tablet
Route: Oral

This form will not be accepted without a Physician's signature.

Indication for use: An elevated temperature of 101F or greater, or for severe pain due to an acute condition. Per parent request, Tylenol may also be administered for menstrual cramps.

DOSAGE

Between 36-47lbs:	240mg
Between 48-59lbs:	320mg
Between 60-71lbs:	400mg
Between 72-95lbs:	480mg
Above 95lbs:	640mg

FREQUENCY

May repeat every 4 hours, not to exceed 5 doses in 24 hours. Over-the-counter medications will not be given for more than three consecutive days without an updated order from a physician. To ensure that the use of this medication is not masking symptoms or any serious condition, a Physician's Order must be submitted to the school for administration of non-prescription medications beyond the recommended product label instructions.

Procedure: Call parents or legal guardian. Monitor student closely until symptoms resolve.

Additional Instructions: _____

Parent/Legal Guardian Name

Print: _____

Signature: _____

Date: _____

Healthcare Provider Name

Print: _____

Signature: _____

Date: _____ Phone: _____

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Health Office

****OPTIONAL****

OVER-THE-COUNTER MEDICATION FORM (2016-2017 SCHOOL YEAR)

Over-the-counter Medications available at Leman Academy with Physician Order

Student Full Name: _____ DOB: _____

Allergies: _____ Weight: _____ lbs

Medication: **Motrin or Generic Equivalent**
Strength: 100mg chewable tablet
Route: Oral

This form will not be accepted without a Physician's signature.

Indication for use: An elevated temperature of 101F or greater, or for severe pain due to an acute condition. Per parent request, Motrin may also be given for menstrual cramps.

DOSAGE

Between 36-47lbs: 1½ tablets (150mg)
Between 48-59lbs: 2 tablets (200mg)
Between 60-71lbs: 2 ½ tablets (250mg)
Above 72lbs: 3 tablets (300mg)

FREQUENCY

May repeat every 6-8 hours, not to exceed 4 doses in 24 hours. Over-the-counter medications will not be given for more than three consecutive days without an updated order from a physician. To ensure that the use of this medication is not masking symptoms or any serious condition, a Physician's Order must be submitted to the school for administration of non-prescription medications beyond the recommended product label instructions.

Procedure: Call parents or legal guardian. Monitor student closely until symptoms resolve.

Additional Instructions: _____

Parent/Legal Guardian Name

Print: _____

Signature: _____

Date: _____

Healthcare Provider Name

Print: _____

Signature: _____

Date: _____ Phone: _____

Medication: **Tums or Generic Antacid Equivalent**
Strength: 500mg Calcium Carbonate
Route: Oral

This form will not be accepted without a Physician's signature.

Indication for use: For complaints of minor stomach discomfort.

Dosage: One chewable tablet

Frequency: May repeat one tablet in 15 minutes. May repeat dose hourly if symptoms return, not to exceed 4 tablets in 24 hours. Over-the-counter medications will not be given for more than three consecutive days without an updated order from a physician. To ensure that the use of this medication is not masking symptoms or any serious condition, a Physician's Order must be submitted to the school for administration of non-prescription medications beyond the recommended product label instructions.

Procedure: Call parents or legal guardian. Monitor student closely until symptoms resolve.

Additional Instructions: _____

Parent/Legal Guardian Name

Print: _____

Signature: _____

Date: _____

Healthcare Provider Name

Print: _____

Signature: _____

Date: _____ Phone: _____

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LEMAN ACADEMY
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Health Office

****OPTIONAL****

OVER-THE-COUNTER MEDICATION FORM (2016-2017 SCHOOL YEAR)

Over-the-counter Medications available at Leman Academy with Physician Order

Student Full Name: _____ DOB: _____

Allergies: _____ Weight: _____ lbs

Medication: **Generic Cough Drop**
Strength: 7.5mg Menthol
Route: Oral

This form will not be accepted without a Physician's signature.

Indication for use: For local soreness or irritation to mouth and gums, and for minor sore throats due to the common cold.

Dosage: Children age 5 and older - One (1) lozenge

Frequency: May repeat one lozenge every two hours as needed. Over-the-counter medications will not be given for more than three consecutive days without an updated order from a physician. To ensure that the use of this medication is not masking symptoms or any serious condition, a Physician's Order must be submitted to the school for administration of non-prescription medications beyond the recommended product label instructions.

Procedure: Call parents or legal guardian. Monitor student closely until symptoms resolve.

Additional Instructions: _____

Parent/Legal Guardian Name

Print: _____

Signature: _____

Date: _____

Healthcare Provider Name

Print: _____

Signature: _____

Date: _____ Phone: _____

PARENT SIGNATURE REQUIRED:

I hereby request and give my consent for the school nurse, or school personnel designated by the Principal and in consultation with the school nurse, to administer the medication indicated above. I give the school nurse permission to discuss my child's medication with the above named Physician. I understand that it is my responsibility to notify the school immediately in writing if there are any changes in medication. In return for the school's assistance in administering the medication, I hereby waive any claim for injury against the school, or its employees, arising from the medication administration.

Parent/Legal Guardian Name

Print: _____

Signature: _____

Date: _____

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LEMAN ACADEMY
of EXCELLENCE

Health Office

MEDICATION POLICY

If a student requires medication during the school day, the following criteria must be met:

1. All medication (prescription or non-prescription) must be accompanied by written instruction from the Medical Doctor, Doctor of Osteopathy, Dentist, Physician Assistant, or Nurse Practitioner. The pharmacy label can fulfill this written requirement for prescription drugs only.

2. The request for administration of prescription or non-prescription medication must be accompanied by parent/guardian written authorization. This permission form may be obtained at the school health office.

3. All prescription medication is to be in its original labeled pharmacy container. Medication must be accompanied by a health professional's written request for administration, which includes:

    a. Name of student
    b. Name of medication
    c. Name of qualified healthcare professional
    d. Dosage and route of administration
    e. Dated
    f. Time or indication of administration

4. Students are generally not permitted to carry medication while at school. Exceptions are inhaler medications or medications for life-threatening conditions, provided the necessary requirements are met.

5. Students are permitted to carry asthma inhaler medication in school if the following criteria are met:

    a. A written statement from the physician that provides the name of the drug, dose, times when the medication is to be taken, and the reason the medicine is to be taken.

    b. The health care provider shall indicate via written statement that the child is qualified and able to self-administer the medication.

    c. A school parental permission form for inhalers is completed. Parents and students must sign the waiver on the permission form, relieving the school and its personnel of any responsibility for the benefits or consequences of the medication and that the school bears no responsibility for ensuring that the medication is taken.

    d. The school reserves the right to withdraw permission at any time if the student is unable to demonstrate responsible behavior in carrying and/or taking this medication.

Authorized 6/2015

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AUTHORIZATION FOR RELEASE

Please fill in previous school name and address below.

_____

_____

_____

_____

Subject: **RECORDS REQUEST**

Student Name: _____ Date of Birth: ____/_____/____

SAIS #: _____ Last Grade Completed: _____

- ☐ **STUDENT EDUCATIONAL RECORDS (Withdrawal Grades/Transcripts/Report Cards)**
- ☐ **STATE/LOCAL TEST SCORES**
- ☐ **HEALTH/IMMUNIZATION RECORDS**
- ☐ **DISCIPLINE RECORDS**
- ☐ **ATTENDANCE RECORDS**
- ☐ **OFFICIAL WITHDRAWAL FORM**
- ☐ **IEP (IF APPLICABLE)**
- ☐ **BIRTH CERTIFICATE**
- ☐ **PSYCHOLOGICAL REPORTS**
- ☐ **SOCIOLOGICAL HISTORY REPORTS**
- ☐ **EDUCATIONAL REPORTS**

To release and/or exchange records with »
Please Mail or Fax to »

Leman Academy of Excellence
7720 N Silverbell Rd, Bldg 1 & 2
Tucson, AZ 85743

Fax: 520-395-1352

Date: _____ Authorized Signature: _____

Parental Permission is not required when authorized school personnel request records. (Family Educational Rights) and Privacy Act, Final Rule on Education Records, Federal Register, June 17, 1976, Vol. 41, No. 118, Page 24673

For Official Use Only

Date: 1st Request Sent_____ 2nd Request Sent _____ Received _____

LEMAN ACADEMY of EXCELLENCE

ARIZONA RESIDENCY FORMS

On September 22, 2011, the Arizona Department of Education provided guidelines to determine the residency of all public school students registered in the State of Arizona. Pursuant to A.R.S. §15-823(J), a school district or charter school may not include non-resident pupils in their student count, therefore not receiving state aid for these pupils. The residency of a student is determined by the residency of the parent or guardian with whom the student lives. Accordingly, it is the responsibility of the school receiving state aid to ensure that student residency information is accurate and verifiable. The following documents must be completed by each parent/guardian registering a student at Leman Academy of Excellence.

The documentation required by law must be provided each time a student enrolls in a public school in Arizona, being maintained in the records retention schedule for each school.

One of the following document forms is required for each student attending school, being completed during the registration process and maintained in the student's file.

- **Arizona Residency Documentation Form** – To be completed by parents/guardians that maintains his/her own residence and is able to provide documentation bearing his/her name and address.

- **Affidavit of Shared Residence** – To be completed by parents/guardians that do not maintain his/her own residence due to extenuating circumstances including, but not limited to, that the family's household is multi- generational.

MUST MATCH PHYSICAL ADDRESS PROVIDED ON THE ONLINE ENROLLMENT FORM

Arizona Department of Education
Arizona Residency Documentation Form

Student: _____ School: Leman Academy of Excellence

School District or Charter Holder: Leman Academy of Excellence

Parent/Legal Guardian: _____

As the Parent/Legal Guardian of the Student, I attest that I am a resident of the State of Arizona and submit in support of this attestation a copy of the following document that displays my name and residential address or physical description of the property where the student resides:

- — Valid Arizona driver's license, Arizona identification card or motor vehicle registration
- — Valid U.S. passport
- — Real estate deed or mortgage documents
- — Property tax bill
- — Residential lease or rental agreement
- — Water, electric, gas, cable, or phone bill
- — Bank or credit card statement
- — W-2 wage statement
- — Payroll stub
- — Certificate of tribal enrollment or other identification issued by a recognized Indian tribe
- — Documentation from a state, tribal or federal government agency (Social Security Administration, Veteran's Administration, Arizona Department of Economic Security)
- — I am currently unable to provide any of the foregoing documents. Therefore, I have provided an original affidavit signed and notarized by an Arizona resident who attests that I have established residence in Arizona with the person signing the affidavit.

_____ _____

Signature of Parent/Legal Guardian Date

State of Arizona Affidavit of Shared Residence

I swear or affirm that I am a resident of the State of Arizona and that the persons listed below reside with me at my residence, described as follows:

Persons who reside with me: _____

_____

Location of my residence: _____

_____

I submit in support of this attestation a copy of the following document that displays my name and current residence address or physical description of my property:

- — Valid Arizona driver's license, Arizona identification card or motor vehicle registration
- — Valid U.S. passport
- — Real estate deed or mortgage documents
- — Property tax bill
- — Residential lease or rental agreement
- — Water, electric, gas, cable, or phone bill
- — Bank or credit card statement
- — W-2 wage statement
- — Payroll stub
- — Certificate of tribal enrollment or other identification issued by a recognized Indian tribe.
- — Documentation from a state, tribal or federal government agency (Social Security Administration, Veteran's Administration, Arizona Department of Economic Security)

Printed Name of Affiant: _____

Signature of Affiant: _____

Acknowledgement

State of Arizona County of: _____

The foregoing was acknowledged before me this_____ day of _____, 20_____,

By _____.

_____ My Commission Expires:

Notary Public _____

LEMAN ACADEMY
of EXCELLENCE

Leman Academy of Excellence Verification of Student Date of Birth

A.R.S. § 15-828-A states: On enrollment of a student for the first time in Leman Academy of Excellence, the school shall notify the person enrolling the student, in writing, that within thirty (30) days one of the following must be provided:

A. A certified copy of the student's birth certificate, or

B. Other proof of the student's identity and age including:

1. Baptismal Certificate and an affidavit explaining the inability to provide a copy of the birth certificate.

2. Application for Social Security number and an affidavit explaining the inability to provide a copy of the birth certificate.

3. Original school registration records and an affidavit explaining the inability to provide a copy of the birth certificate.

4. Letter from the authorized representative of an agency having custody certifying that the student has been placed in the custody of the agency as prescribed by law.

This section applies only to kindergarten and first grade enrollment.

In accordance with A.R.S. § 15-828, continued enrollment of my child is contingent upon appropriate proof of age for kindergarten and grade one per A.R.S. § 15-821.

Child's Name: _____ DOB: _____/_____/_____

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

A.R.S. § 15-821-C states: "If a kindergarten is maintained, a child shall be eligible for admission to kindergarten if he is five years of age prior to September 1 of the current school year. The governing board may admit children who have not reached the required age if it is determined to be in the best interest of the child." Such children must reach the required age of five for kindergarten and six for first grade by December 31st of the current school year.

LEMAN ACADEMY
of EXCELLENCE

STUDENT PHOTOGRAPHY RELEASE & INTERNET USE FORM

This form gives Leman Academy of Excellence authorization to use student information and photographs taken of your child for educational purposes, including yearbook, newsletters, newspaper, flyers, brochures, website, announcements and other publicity.

(Please Check Only ONE Option)

☐ I approve of Student Information and Photograph Release without reservation, compensation or restrictions.

☐ I approve of Student Information and Photograph Release for school/class pictures and Yearbook. I understand these pictures will only be used for individual pictures, class pictures, and Yearbook.

☐ I DO NOT approve of any Student Information or Photograph Release for my child. I understand this means my child may not be photographed or interviewed under any circumstances including outside agencies. (Please Note: This option includes, but is not limited to, school pictures (individual), class pictures and/or yearbook pictures).

☐ I DO hereby give permission to allow access to the Internet for my student. I may withdraw my permission at any time and the student's access will be denied immediately. Any Leman Academy staff member may also cancel the student's access at any time for any reason.

☐ I DO NOT give permission to allow access to the Internet for my student.

I understand that I may revoke or change these permissions at any time. In order to do so, I will need to complete and resubmit this document to the Office.

Student Name: _____

Parent Name: _____

X _____ _____/_____/_____

Parent/Guardian SIGNATURE Date

Rev. 8/24/15

State of Arizona
Department of Education
Office of English Language Acquisition Services

Primary Home Language Other Than English (PHLOTE) Home Language Survey

(Effective April 4, 2011)

These questions are in compliance with Arizona Administrative Code, R7-2-306(B)(1), (2)(a-c).

Responses to these statements will be used to determine whether the student will be assessed for English Language Proficiency.

1. **What is the primary language used in the home regardless of the language spoken by the student?** _____
2. **What is the language most often spoken by the student?** _____
3. **What is the language that the student first acquired?** _____

Student Name _____ Student ID _____

Date of Birth _____ SAIS ID _____

Parent/Guardian Signature _____ Date _____

District or Charter: Leman Academy of Excellence

School: Leman Academy of Excellence

Please provide a copy of the Home Language Survey to the ELL Coordinator/Main Contact on site.

In SAIS, please indicate the student's home or primary language.

Estado de Arizona
Departamento de Educación
Servicios de Aprendizaje del Inglés

Idioma Principal en el Hogar excluyendo el inglés (PHLOTE)
Encuesta sobre el Idioma en el Hogar

(Efectivo el 4 de abril de 2011)

Preguntas en conformidad con R7-2-306(B)(1), (2)(a-c) del Reglamento de la Junta Directiva.

Las respuestas que proporcione a las preguntas siguientes serán usadas para determinar si se evaluará la competencia en el idioma inglés de su hijo(a).

1. **¿Cuál idioma se habla principalmente en su hogar sin considerar el idioma que habla el estudiante?** _____
2. **¿Cuál idioma habla el estudiante con mayor frecuencia?** _____
3. **¿Cuál fue el primer idioma que aprendió el estudiante?** _____

Nombre del estudiante _____ Núm. de identificación _____

Fecha de nacimiento _____ Núm. de SAIS _____

Firma del padre o tutor _____ Fecha _____

Distrito o Charter _____

Escuela _____

Please provide a copy of the Home Language Survey to the ELL Coordinator/Main Contact on site.

In SAIS, please indicate the student's home or primary language.

LEMAN ACADEMY
of EXCELLENCE

2016-2017 Full-Day Kindergarten Registration/Payment Form

Parents of children who meet the enrollment requirements (age five by September 1, 2016) for voluntary Kindergarten program at Leman Academy of Excellence may place their child in a half-day Kindergarten instructional program. Leman Academy of Excellence, in accordance with its charter and state law, provides a half-day Kindergarten program that starts at 8:00 AM and ends at 12:00 PM.

Leman Academy seeks to partner with our parents by also offering a full-day Kindergarten program of instruction to give parents a choice that will best meet their family and child's needs, as well as give parents an opportunity to explore the two options (half-day & full-day) in order to determine which option might be best for their child as he/she first enters Kindergarten and all of its expectations. Full-day Kindergarten starts at 8:00 AM and ends at 2:30 PM.

Accordingly, Leman Academy of Excellence will provide an optional, fee based, full-day Kindergarten program to the families of Leman Academy if there is a demand and the parents are seeking such an option for their child. The full-day Kindergarten program fee is $285/month. When selecting this option, the parent/guardian may choose to pay monthly, semi-annually or choose the yearly option and pay in full. If parents choose the yearly option we ask that payment be made prior to the start of the school year and for parents choosing the semester option, we ask that payments be made prior to the start of the school year and the start of the second semester in January. Thank you!

CONTACT INFORMATION: (To be completed by Parent/Guardian)

PRINT Student Name:		Date of Birth:
PRINT Parent/Guardian Name(s):		
Daytime Phone:	Evening Phone:	Cell Phone1:
E-mail:		Cell Phone2:
Emergency Contact:		Phone:

PAYMENT OPTIONS: (To be completed by Parent/Guardian)

FULL-DAY KINDERGARTEN	**Payment Options** (Select One)
Monthly Option -$285	☐
Semester Option - $1,306.25 (5% discount for pre-payment)	☐
Yearly Option - $2,337.50 (15% discount for pre-payment)	☐

Please do not submit payments at this time. A notice will be posted on the website when online and mail-in payments will be accepted along with a notification email.

My signature certifies that I have read and understand the information and financial obligations as stated above.

X _____ _____

Parent/Guardian Signature Date