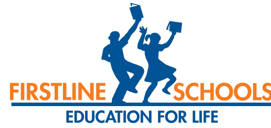


WELCOME TO FIRSTLINE SCHOOLS!
NEW STUDENT
ENROLLMENT PACKET

Please complete the enclosed forms and submit the below required documents:

- ☐ Copy of Student Birth Certificate
- ☐ Copy of Student Social Security Card
- ☐ Copy of Immunization Records
- ☐ One proof of residence (examples include a phone bill, water bill, or lease agreement)
- ☐ Copy of Insurance or Medicaid card
- ☐ Copy of previous report card
- ☐ Copy of high school transcript (for high school students only)

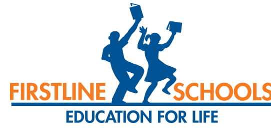
Please also include the following, if applicable:

- ☐ iEP/504
- ☐ Copy of LEAP waiver
- ☐ Copy of LEAP, iLEAP, ACT, and/or EOC Test scores

* 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 CONFIDENTIAL RECORDS RELEASE

Authorization to release student information as per the United States Code "Family Educational Rights and Privacy Act."

Student Last Name | Student First Name | DOB

Parent/Guardian:

The purpose of this form is for you to give permission for FirstLine Schools to request your child's educational records from any previous school(s).

Registrar or Counselor:

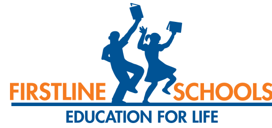
You are hereby authorized to release from your records the following data concerning the student listed below.

- ☐ Standardized test data
- ☐ Scholastic achievement data
- ☐ Medical data/immunizations
- ☐ Birth Certificate
- ☐ Social Security Number
- ☐ IEP Records

Student's Previous School History			
	Grade	School Name	City, State
1			
2			
3			
4			
5			

I authorize the staff of FirstLine Schools to request educational records for my student from any previous school(s).

Parent or Guardian Name | Signature | Date



FIRSTLINE SCHOOLS ENROLLMENT APPLICATION

Last Name | First Name | Middle Name

Date of Birth: ___/___/___
Gender: ☐ Male ☐ Female
Social Security Number (optional): ____-____-____.

School Enrolling Into (please check one):
- ☐ Arthur Ashe Charter School
- ☐ Samuel J. Green Charter School
- ☐ Phillis Wheatley Community School (formerly John Dibert)
- ☐ Langston Hughes Academy
- ☐ Joseph S. Clark Preparatory H.S.

How did you hear about us (CHECK ALL THAT APPLY):
- ☐ A Friend
- ☐ Another FirstLine Family. If yes, please list the family:
- ☐ A bus shelter ad
- ☐ A bus ad
- ☐ Radio
- ☐ Flyer
- ☐ Facebook

Grade level last year:

Previous school:

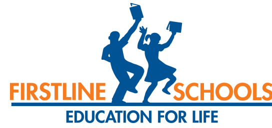
NAME | CITY, STATE

Mailing Address:

Street Address | CITY, STATE

Previous school:

Street Address | CITY, STATE



FirstLine Schools provides transportation service to all students who reside in Orleans Parish and at least one mile from the campus at which they are enrolled. Students in K-2 must have an adult at the stop to pick them up.

Please indicate below how this student will arrive at school in the morning (AM) and depart in the afternoon (PM).

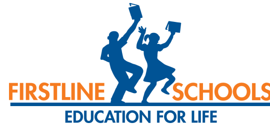
Morning:

- ☐ Walk
- ☐ Car
- ☐ Bus
- ☐ RTA

Afternoon:

- ☐ Walk
- ☐ Car
- ☐ Bus
- ☐ RTA

STUDENT'S PERSONAL PHONE: ______________________ (IF APPLICABLE)



Last Name First Name Middle Name

PARENT/GUARDIAN CONTACT INFORMATION

Parent/ Guardian NAME Home Phone Secondary Phone

Email address

Street Address CITY, STATE

Contact me via email? ☐ Yes ☐ No
Contact me via text message? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

NAME Home Phone Secondary Phone

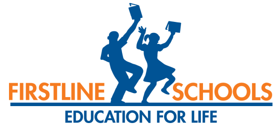
Street Address CITY, STATE

NAME Home Phone Secondary Phone

Street Address CITY, STATE

(ONLY LIST PEOPLE ALLOWED TO CHECK OUT OR PICK UP THE STUDENT)

NAME	RELATION TO STUDENT	MAIN PHONE	OTHER PHONE	EMAIL ADDRESS	LIVES WITH STUDENT?
					☐ Yes ☐ No



					☐ Yes ☐ No
					☐ Yes ☐ No

Please list any people NOT allowed to check out or pick up the student:

Parent/Guardian (print) Parent/Guardian Signature Date

Louisiana Department of
EDUCATION

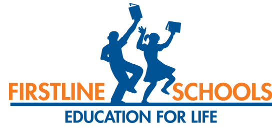
Louisiana Student Residency Questionnaire Form

(Form Must Be Included In School Enrollment Packet)

Student Last Name   Student First Name   DOB

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)
   a. In an emergency/transitional shelter. ☐ Awaiting foster care placement.
   b. Temporarily with another family because we cannot afford or find affordable housing.
   c. With an adult that is not a parent or legal guardian, or alone without an adult.
   d. In a vehicle of any kind, trailer park or campground without running water/electricity, abandoned building or substandard housing.
   e. Emergency Housing (i.e. FEMA Trailer or FEMA Rental Assistance)
   f. 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
7. Other? (Describe: ______________________________)
8. 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?
9. ☐**Yes** ☐**No** Does your child have siblings (brothers or sisters)?
10. ☐**Yes** ☐**No** Do you need translation services? If yes, which language?
11. ☐**Yes** ☐**No** Do you need an interpreter for concerns involving your child's education? If yes, which language?



12. The undersigned certifies that the information provided above is accurate.

Parent/Guardian (print) Parent/Guardian 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 or Doubled-Up ☐ Unsheltered/FEMA ☐ Hotel/Motel Unaccompanied Youth ☐Yes ☐No ☐Awaiting Foster Care Placement

Print School Contact Title Signature (required) Date (Revised 3/2012)

Student Last Name Student First Name DOB

FIRSTLINE SCHOOLS
EDUCATION FOR LIFE

FIRSTLINE SCHOOLS FIELD TRIP AUTHORIZATION

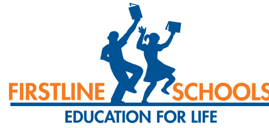
I permit my child to participate in field trips while they are enrolled at FirstLine Schools.

I understand that the school will take all reasonable precautions to ensure against the possibility of accidents. However, I understand that this school or the adult in charge is not liable for accidents occurring to children either on school premises or while on field trips as part of the school's activities.

Information concerning a specific field trip such as date, time of departure, destination, cost, and means of transportation will be sent to me by the teacher prior to each field trip.

____

Parent/Guardian (print)　　　　Parent/Guardian Signature　　　　Date



FIRSTLINE SCHOOLS MEDIA RELEASE

Student Last Name	Student First Name	DOB

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 my child is enrolled a FirstLine School where outside media or others may visit the school or school event and wish to photograph, videotape, or interview the child.

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, televisions, 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.

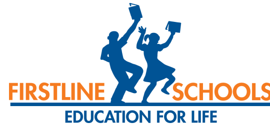
I understand that by signing this waiver I agree to my child's image and likeness being used in educational, promotional and marketing materials, on social media sites such as Twitter, FaceBook, Instagram, blogs, in press releases, on websites, radio stations, news stations, on television, and any other media outlet.

I certify that I have read the Media Consent and Release Liability statement and fully understand its terms and conditions.

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 aforedescribed 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.

____
School Name

Parent/Guardian (print)	Parent/Guardian Signature	Date



FIRSTLINE SCHOOLS RACE/ETHNICITY SURVEY

Student Last Name	Student First Name	DOB

Place of Birth (City, State, Country): ______________________

If place of birth is outside the U.S., what was the date (month and year) of initial arrival to the U.S.?

Month:

Year:

Is this student of Hispanic or Latino culture or origin? ☐**Yes** ☐**No**

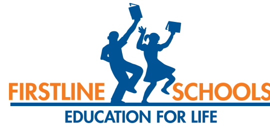
Select one or more of the following races:

- ☐ African American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline to state.

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 in your home? ☐**Yes** ☐**No**
2. **If NO, go to numbers 7 and 8.** If **YES**, what is that language? ______________
3. Is that language spoken in the home ☐MORE OFTEN than **English**? ☐LESS OFTEN than **English**?
4. What language is spoken by adults in the home? ______________
5. What was the first (1st) language your child learned to speak? ______________
6. Do you need translation services? If yes, which language?
7. Do you need an interpreter for concerns involving your child's education? If yes, which language?
8. Parent/Guardian Name:______________
9. Parent/Guardian Signature:______________ Date: ______________



FIRSTLINE SCHOOLS STUDENT NEEDS SURVEY

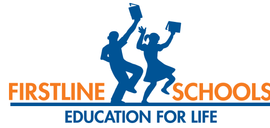
Student Last Name Student First Name DOB

Please provide as much information on your child so we can provide them with appropriate services. Your responses have no impact on your child's admittance into school, as your child has already been accepted.

SPECIAL EDUCATION/504/IEP	Yes	No	Don't Know
My child has received special education services.			
I would like for my child to be evaluated for Special Education Services.			
My child has an Individual Education Plan (IEP). If so, please provide a copy of his/her IEP or list which school would have a copy of his/her IEP form: __ ___ _________ ______ __			
My child receives services under 504 Rehabilitation Act.			
My child has been evaluated for special education services. Date:____________Location:_________________			

ADDITIONAL INFORMATION	Yes	No	Notes
My child has been retained? (If Yes, Grade)			
My child has been suspended (If Yes, reason and # of times)			
My child has been expelled (If Yes, when)			

Additional comments:



Student Last Name | Student First Name | DOB

MEDICAL RELEASE

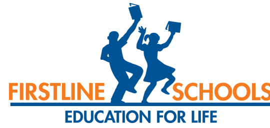
Insurance Provider & Group Number | Plan

Primary Insured | Insured Date of Birth | Employer

Hospital/Clinic 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 or Guardian Name | Signature | Date



OPTIONAL HEALTH SCREENING AUTHORIZATION

Your child's health and well-being are important to us. We want to assist you in ensuring that all students are provided with the tools that they need for success. To that end, we have compiled a list of vendors that we maintain relationships with. With your consent, they can provide the listed services. All services are optional and coordinate with school nursing services. By signing below, you authorize coordination of services for your child during the school year. You may opt out at any time.

VISION SERVICES	AUDIOLOGY SCREENS	DENTAL SCREENS
On Site Eye Care	The Lion's Club	Gentilly Family Dental LLC
Tots and Teens EyeCare	New Orleans Speech and Hearing	Dr. Ambrose Martin DDS
Dr. Daphe Richardson	Dr. Joe Melcher (Xavier University)	Mobile Dental Unit (Children's)
For Your Eyes Only 20/20	Nurse Nikki LLC	Dr. Jimani Mwendo DDS
Dr. Jeff Silbernagel	LSU Audiology Clinic	

Eye History: ☐Eye Surgery ☐Eye Turn (Strabismus) ☐Itching ☐Injury ☐Other:

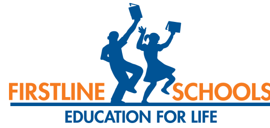
Complete Assessment may involve eye dilation. This may cause light sensitivity/blur for 3-4 hours. Disposable sunglasses will be provided. ☐***Yes***, I give permission for dilation. ☐***No***, I prefer that my child's eyes not be dilated.

Hearing/Dental History: ☐Latex Allergy ☐Congenital Hearing Difficulty ☐Hearing Aids ☐Other:

By signing below, I authorize FirstLine Schools to retain the services of one or more of the care providers listed above to provide services to my child during the academic year. I acknowledge that this is a voluntary consent and I can revoke consent at any time. This document will serve as consent for service between the vendor and the parent or guardian.

____

Parent or Guardian Name Signature Date



STATE OF LOUISIANA HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent / Legal Guardian is encouraged to participate in the development of an individual health plan if needed. Use additional sheets, if necessary, for further explanation.

Name of School:			Grade:
Student's Name: Last First M.I.			DOB:
Sex: ☐F ☐M	**Student's Address:** **House/Apt. #** **Street Name** **City, State ZIP**		
Name of Mother or Legal Guardian:	Home Phone:	Cell Phone:	Work Phone:
Name of Father or Legal Guardian:	Home Phone:	Cell Phone:	Work Phone:
Name of child's Primary Care Physician/Provider:	Phone Number:	Dentist Name:	

Name of any medical specialists or special clinics caring for your child:

Parent or Guardian Legal Signature *Date*

Please check the type of health insurance that covers your child: ☐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: *Complete phone number: (   )* *Relationship:*

( )

DOES YOUR CHILD HAVE A MEDICAL, MENTAL OR BEHAVIORAL CONDITION THAT MAY AFFECT HIS/HER SCHOOL DAY?

☐**NO** ☐**YES – *if yes, please complete part 2 below.***

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 any special food or equipment that the student may require during the school day. Check with the school nurse to obtain correct medication and procedure forms.

☐ **ALLERGIES**

Allergy Type:

- ❑ Food (List foods): ____________________
- ❑ Insect sting (list insects):____________________
- ❑ Medication (list medications): ____________________
- ❑ Other (list): ____________________ Rec
- ❑ Coughing (Date:__________) ☐Hives (Date:__________) ☐Rash (Date:__________)
- ❑ Difficulty Breathing (Date:_____ ☐Local Swelling (Date:__________) ☐Wheezing (Date:_________)
- ❑ General Swelling (Date:____) ☐Nausea (Date:__________) ☐Other (Date:__________)

Currently prescribed medications and treatments:

☐ Oral Antihistamine ☐Epi-pen ☐ Other: __________________

FIRSTLINE SCHOOLS
EDUCATION FOR LIFE

☐ **ASTHMA**
Triggers: qEnvironmental (i.e., tobacco, dust, pets, pollen, etc.) LIST HERE:____________________ ☐Other (list):____________
Does your child experience asthma symptoms with exercise? ☐**Yes** ☐**No**
Symptoms: ☐Chest tightness, discomfort or pain ☐Difficulty breathing ☐Coughing ☐Wheezing ☐Other

Currently prescribed medications or treatments:

Date of last hospital treatment related to asthma:
Does your child have a written asthma management plan? ☐**Yes** ☐**No**
Is peak flow monitoring used? ☐**Yes** ☐**No**

☐ **DIABETES**
Currently prescribed medications and treatments:
- ❑ Insulin: >> ☐Syringe ☐Pen ☐Pump
- ❑ Blood sugar testing
- ❑ Glucagon
- ❑ Oral Medication: >>> List medications: ____
- ❑ Is special scheduling of lunch or Physical Education required? ☐**Yes** ☐**No**

☐ **SEIZURE DISORDER**
Type of Seizure:
- ❑ Absence (staring, unresponsive) ☐Complex partial ☐Generalized Tonic-Clonic (Grand Mal / Convulsive)
- ❑ Other (explain)

Physical Education restrictions? ☐**Yes** ☐**No**
Medications: ☐**Yes** ☐**No** List Medications: ____

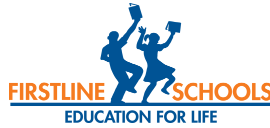
Date of Last seizure:___________________________Length of seizure: ________________________________

☐ **OTHER HEALTH CONDITIONS**
- ☐ Anemia ☐ADD/ADHD ☐Cancer ☐Cerebral Palsy ☐Chicken Pox ☐Cystic Fibrosis
- ☐ Depression ☐Digestive disorder ☐Emotional / Psychological qJuvenile Rheumatoid Arthritis
- ☐ Hemophilia ☐Heart condition ☐Physical disability ☐Sickle Cell Disease ☐Skin Disorder ☐Speech Problems
- ☐ OTHER (explain): ____

Physical Education Restrictions? ☐NO ☐YES (explain) ____
Medications? ☐NO ☐YES List medications:____

❑ NO ☐YES (explain) ____
Are there anticipated frequent absences or hospitalizations? ☐NO ☐YES (Explain) ______________________________

☐**VISION CONDITIONS**	☐**HEARING CONDITIONS**
❑ Contacts ☐Glasses ❑ Other (explain):	❑ Hearing aid(s) ❑ Other (explain):



☐**ENVIRONMENTAL ADJUSTMENTS DUE TO HEALTH CONDITION(S)**

Are special adjustments of the school environment or schedule necessary? (i.e., limitations in physical activity, breaks for endurance, part-time schedule, building modifications for access)

❑ NO ☐YES (explain) ____

Are special school adjustments to the classroom necessary? (i.e., temperature, refrigeration/ medication storage, availability of running water)

❑ NO ☐YES (explain) ____

Are there special safety considerations? (i.e., precautions in lifting, positioning, transportation, emergency plan, safety equipment, feeding)

❑ NO ☐YES (explain) ____

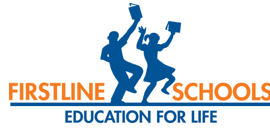
Does your student require special assistance with activities of daily living? (i.e., eating, toilet, walking)

❑ NO ☐YES (explain) ____

PART 3: SCHOOL NURSE TO COMPLETE. (Firma de la enfermera si padre/tutor indica una condicion

School Nurse signature : **Date:**

Notes:



NOTICE AND CONSENT REGARDING MEDICAID REIMBURSEMENT
(Only required for students on Medicaid)

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.

______________________________	______________________________
Name of Student	Date
______________________________	______________________________
Parent or Guardian Signature	Relationship to Student