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## STUDENT REGISTRATION MAIL-IN FORMS COVER LETTER

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**Choose Location:**

TUCSON

SIERRA VISTA

MESA

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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
- 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.

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ALL forms and documents should be **HANDED IN AT SCHOOL** or **MAILED / FAXED** to the below. Forms and documents are **NOT** to be emailed per HIPAA compliance.

**TUCSON & SIERRA VISTA send to the below:**

Leman Academy of Excellence  
7720 N Silverbell Rd, Bldg 1 & 2  
Tucson, AZ 85743  
Fax: (520) 395-1352

**MESA send to the below:**

3761 S. Power Road  
Mesa, AZ 85212



CDC/SGH# or name: \_\_\_\_\_

**Arizona Department of Health Services  
Bureau of Child Care Licensing  
Emergency, Information and Immunization Record Card**

<b>Child's Name:</b>	<b>Date Enrolled:</b>	<b>Updated:</b>
<b>Home Address (#, Street, City, State, Zip Code):</b>		<b>Date Disenrolled:</b>
<b>Home Phone:</b>	<b>Date of Birth:</b>	<b>Sex:</b> <input type="checkbox"/> male <input type="checkbox"/> female

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

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

**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.)**

<b>Name:</b>	<b>Contact Telephone Number:</b>
<b>Name:</b>	<b>Contact Telephone Number:</b>
<b>Name:</b>	<b>Contact Telephone Number:</b>
<b>Name:</b>	<b>Contact Telephone Number:</b>

If Medical care is necessary, call:

<b>Health Care Provider*</b>	<b>Name:</b>	<b>Contact Telephone Number:</b>
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\*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

<b>In case of injury or sudden illness, I request that this individual be called first:</b>	
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The following individual(s) may NOT remove my child from the facility:

<b>Name(s):</b>
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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](http://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:

<input type="checkbox"/>	Copy of current official documented immunization record attached
<input type="checkbox"/>	Religious Beliefs exemption form signed by parent/guardian attached
<input type="checkbox"/>	Medical Exemption form signed by physician and parent/guardian attached
<input type="checkbox"/>	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**

<p>Is child allergic to food or other substances? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:</p>
<p>Is child usually susceptible to infections and if so, what precautions need to be taken? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, list precautions:</p>
<p>Is child subject to convulsions and what should be our procedure if one occurs? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, specify procedure:</p>
<p>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.)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, list precautions:</p>
<p>Additional comments:</p>
<p>Other special instructions:</p>

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:
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## **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*



Health Office

**\*\*OPTIONAL\*\***

**PERMISSION FORM  
ADMINISTERING PRESCRIPTION MEDICATION AT SCHOOL**

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

Choose Location:  TUCSON  SIERRA VISTA  MESA

Student Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs

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: \_\_\_\_\_

Pharmacy and 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 its 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



Health Office

**\*\*OPTIONAL\*\***

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

Choose Location:  TUCSON  SIERRA VISTA  MESA

Student Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs

**\*\*HEALTH CARE PROVIDER SIGNATURE REQUIRED\*\***

Health Care Provider and Parent/Caregiver permission to administer the following medications at school, as outlined on page 2 and 3 of order form or as indicated below:

_____ <b>Healthcare Provider Initial</b> _____ <b>Parent/Caregiver Initial</b>	<b>BENADRYL</b> or generic equivalent as ordered below. Additional instructions: _____ _____
_____ <b>Healthcare Provider Initial</b> _____ <b>Parent/Caregiver Initial</b>	<b>TYLENOL</b> or generic equivalent as ordered below. Additional instructions: _____ _____
_____ <b>Healthcare Provider Initial</b> _____ <b>Parent/Caregiver Initial</b>	<b>MOTRIN</b> or generic equivalent as ordered below. Additional instructions: _____ _____
_____ <b>Healthcare Provider Initial</b> _____ <b>Parent/Caregiver Initial</b>	<b>TUMS</b> or generic equivalent as ordered below. Additional instructions: _____ _____
_____ <b>Healthcare Provider Initial</b> _____ <b>Parent/Caregiver Initial</b>	<b>GENERIC COUGH DROP</b> as ordered below. Additional instructions: _____ _____

<p><b>Health Care Provider Initial and Sign Below:</b></p> <p>Print: _____</p> <p>Initial: _____</p> <p>Signature: _____</p> <p>Date: _____</p> <p>Phone: _____</p>	<p><b>Parent or Caregiver Initial and Sign Below:</b></p> <p><i>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.</i></p> <p>Print: _____</p> <p>Initial: _____ Signature: _____</p> <p>Date: _____</p>
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**\*\*OPTIONAL\*\***

**OVER-THE-COUNTER MEDICATION FORM (2016-2017 SCHOOL YEAR)**  
Over-the-counter Medications available at Leman Academy with Physician Order

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

**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.

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

**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.

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

**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.



Health Office

**\*\*OPTIONAL\*\***

**OVER-THE-COUNTER MEDICATION FORM (2016-2017 SCHOOL YEAR)**  
Over-the-counter Medications available at Leman Academy with Physician Order

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

**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.

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

**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.





## AUTHORIZATION FOR RELEASE

Please fill in previous school name and address below.

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Subject: **RECORDS REQUEST**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SAIS #: \_\_\_\_\_ Last Grade Completed: \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> <b>STUDENT EDUCATIONAL RECORDS</b><br>(Withdrawal Grades/Transcripts/Report Cards) | <input type="checkbox"/> <b>IEP (IF APPLICABLE)</b>          |
| <input type="checkbox"/> <b>STATE/LOCAL TEST SCORES</b>   | <input type="checkbox"/> <b>BIRTH CERTIFICATE</b>            |
| <input type="checkbox"/> <b>HEALTH/IMMUNIZATION RECORDS</b>   | <input type="checkbox"/> <b>PSYCHOLOGICAL REPORTS</b>        |
| <input type="checkbox"/> <b>DISCIPLINE RECORDS</b>  | <input type="checkbox"/> <b>SOCIOLOGICAL HISTORY REPORTS</b> |
| <input type="checkbox"/> <b>ATTENDANCE RECORDS</b>  | <input type="checkbox"/> <b>EDUCATIONAL REPORTS</b>          |
| <input type="checkbox"/> <b>OFFICIAL WITHDRAWAL FORM</b>  |  |

*To release and/or exchange records with the below. Please Mail or Fax to checked school.*

- PLEASE CHECK THE CORRESPONDING BOX BELOW -

**TUCSON / MARANA**  
Leman Academy of Excellence  
7720 N Silverbell Rd, Bldg 1 & 2  
Tucson, AZ 85743  
Fax: 520-395-1352

**SIERRA VISTA**  
Leman Academy of Excellence  
1000 E Wilcox Dr.  
Sierra Vista, AZ 85635  
Fax: 520-395-1352

**MESA**  
Leman Academy of Excellence  
3761 S. Power Rd.  
Mesa, AZ 85212

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 \_\_\_\_\_



## 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.

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**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**



## 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 \_\_\_\_\_.

\_\_\_\_\_

Notary Public

My Commission Expires:

\_\_\_\_\_



## Arizona Department of Education Arizona Residency Documentation Form

Student: \_\_\_\_\_ School: Lemman Academy of Excellence

School District or Charter Holder: Lemman 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



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## 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.
  - 5.

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**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.

Choose Location:	<input type="checkbox"/> TUCSON	<input type="checkbox"/> SIERRA VISTA	<input type="checkbox"/> MESA
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Child's Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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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.



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: Lemna Academy of Excellence

School: Lemna Academy of Excellence

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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 \_\_\_\_\_

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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.



## 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)

Choose Location:	<input type="checkbox"/> TUCSON	<input type="checkbox"/> SIERRA VISTA	<input type="checkbox"/> MESA
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	PaymentOptions (Select One)
Monthly Option -\$285	<input type="checkbox"/>
Semester Option - \$1,306.25 (5% discount for pre-payment)	<input type="checkbox"/>
Yearly Option - \$2,337.50 (15% discount for pre-payment)	<input type="checkbox"/>

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