

CHS Summer School Registration Form for New Students (And Non CCS Students)

This form must be filled out in order to attend summer school classes at Centerville High School. You will receive confirmation of your summer school class placement by April 9, 2020.

*****Please also complete the Emergency Medical Form and bring both forms and payment to the West Unit office at CHS starting March 13, 2020*****

First Name: _____ Last Name: _____

Student Address: _____

Parent Phone #: _____ Parent Email: _____

School Attending for the 2020-20 School Year: _____

Grade for 2020-21 School Year: _____

Session #1 (June 1-June 19): \$115.00 TUITION FEE FOR SESSION I

- US Government (#1345)
- 9th Modern World History (#13061)
- Health (#1703) **\$4.00 lab fee**
- PE (#1706) **\$100.00 lab fee**
- Digital Photography (#1907) **\$70.00 lab fee**
- Computer Applications and Digital Literacy (#15031) **\$5.00 lab fee**

6 Week Courses (June 1-July 10): \$230.00 TUITION FEE FOR 6 WEEK COURSES

- Algebra 1 (#1109)
- Geometry (#1115)
- Chemistry (#1224) **\$20.00 lab fee**
- Physics 1 (#1242-1) **\$20.00 lab fee**

Session #2 (June 22-July 10): \$115.00 TUITION FEE FOR SESSION II

- US Government (#1345)
- Health (#1703) **\$4.00 lab fee**
- PE (#1706) **\$100.00 lab fee**

***Please initial the following line to confirm agreement: Payment is due along with the registration form and the emergency medical form: _____**

***April 9 and after: If a student cancels a class, a \$60.00 non-refundable administrative fee will be added to their bill.**

STUDENT NAME _____
(Please print) Last First (ID #)

Centerville City Schools

EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio Revised Code 3313.712)

Date of Birth _____ Home Phone _____

School _____ Address _____

School Year _____ Grade _____ City _____ Zip _____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. This information will be shared, as necessary, with teachers, bus drivers, administrative staff, health personnel including student nurses, and other school personnel.

Residential Parent or Guardian

Mother's Name _____ Daytime Phone _____ Cell _____

Father's Name _____ Daytime Phone _____ Cell _____

Emergency 1. _____ Daytime Phone _____ Cell _____

Contacts: 2. _____ Daytime Phone _____ Cell _____

3. _____ Daytime Phone _____ Cell _____

STUDENT HEALTH SECTION MUST BE COMPLETED

Required forms are available from your school nurse or www.centerville.k12.oh.us

No medical conditions No allergies Medication allergy: _____

Allergic to: _____

Requires treatment with epi-pen/antihistamine-- *Emergency Allergy Plan/Epinephrine Authorization required*

No medication required for allergy treatment-- *Allergy No Medication Form required*

Asthma

Requires inhaler/nebulizer at school-- *Asthma Action Plan/inhaled asthma medication authorization required*

No inhaler/nebulizer required at school-- *Asthma/No Medication Plan required*

Diabetes Requires Insulin Requires oral diabetes medications _____

Seizure Disorder Type: _____

Requires Emergency rescue medication-- *Contact school nurse for care plan. Prescription/Non-Prescription authorization form required*

No emergency rescue medication require-- *Contact school nurse for care plan*

Heart/blood problems: _____

Other (Specify) _____

Medications taken at home: _____

Medications to be given at school: _____

Requires Prescription/Non-Prescription authorization form

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

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

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital/Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: 1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and 2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian Date

PART II: REFUSAL TO CONSENT

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

Signature of Parent/Guardian Date

1/2018