Gallia County Local Schools
4836 State Route 325, Patriot, OH 45658
Phone 740-379-9085 Fax 740-379-9138
www.gallialocal.org
District IRN# 065680

CHANGE OF PLACEMENT

_____ _____ ___/___/___ _____ _____
Student's Name Grade Date of Birth Age Gender

Date to enroll:_____

GCLS Building to attend_____
Student attended AE____HTE____RVHS____RVM____SGHS____SGM____SWE____VE____SODA____
If enrolling in SODA complete attached Southern Ohio Digital Academy 4 page document

Home Address change:_____N _____Y (If Yes, complete attached Emergency Medical Student Authorization Form)

Bus Boarding Pass Needed:_____N _____Y (If Yes, complete attached Bus Boarding Pass)

Custody/Court Documents updated since last enrollment:_____N _____Y (If Yes, attach a copy)

Health History changes since last enrollment:_____N _____Y (If Yes, complete attached Confidential History Form)

I, the undersigned fully understand that a Change of Placement is occurring with _____.
Student's Name

_____	_____	_____	_____
Guardian Name	Guardian Name	Parent Name	Parent Name
_____	_____	_____	_____
Phone	Phone	Phone	Phone
_____	_____	_____	_____
Email	Email	Email	Email

_____ ___/___/___
Parent/Guardian Signature Date

Penny Coon
Administrative Assistant
gl_pcoon@gallialocal.org
Ext 10012

ASSIGNMENT APPROVAL / /

Gallia County Local Schools

NEW STUDENT BUS BOARDING PASS

School Attending_____

Student Name_____

DOB___/___/___ Age_____ Grade_____

Address_____ City_____ State_____ Zip_____

Guardian Name_____

Phone_____ Emergency Phone_____

_____ ____	_____	_____	_____
Driver Name	Bus#	AM Pickup Time	PM Drop Off Time

APPROVAL STAMP

EMERGENCY MEDICAL STUDENT AUTHORIZATION FORM

SCHOOL _____ DATE _____ GRADE _____

STUDENT NAME _____

HOME ADDRESS _____
BOX STREET/ROAD CITY ST ZIP

MAILING ADDRESS (If different) _____

Is student open enrollment? ____ *Yes* ____ *No* *Resident District* _____

AGE _____ BIRTH DATE _____ GENDER ___ M ___ F

STUDENT LIVES WITH ___ Both Parents ___ Mother Only ___ Father Only ___ Grandparents ___ Other

GUARDIANS NAME

_____

ADDRESS IF DIFFERENT

_____

_____

HOME PHONE _____

CELL PHONE _____

EMAIL ADDRESS

_____

WORK PHONE _____

PLACE OF EMPLOYMENT

_____

STEP-FATHER (IF APPLICABLE)

_____

CELL PHONE _____

MOTHERS MAIDEN NAME

_____

GUARDIANS NAME

_____

ADDRESS IF DIFFERENT

_____

_____

HOME PHONE _____

CELL PHONE _____

EMAIL ADDRESS

_____

WORK PHONE _____

PLACE OF EMPLOYMENT

_____

STEP-MOTHER (IF APPLICABLE)

_____

CELL PHONE _____

OVER ⇨

IF SOMEONE OTHER THAN MOTHER/FATHER HAVE CUSTODY

NAME _____

PHONE NUMBER _____ CELL PHONE _____

EMAIL ADDRESS _____

PLEASE LIST ALL STUDENTS RESIDING THE HOME (who are under the age of 19 or enrolled in a building/school in our district):

LAST	FIRST	GRADE	AGE

PLEASE LIST IN ORDER, PEOPLE TO BE CONTACTED In event child needs to be released to other than care giver (Parents will be contacted first Inless stated otherwise)

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

MEDICAL HISTORY TO WHICH A PHYSICIAN SHOULD BE ALERTED
(ALLERGIES, PHYSICAL IMPAIRMENT, MEDICATIONS BEING TAKEN ETC.)

_____

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 any licensed physician or dentist and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of 2 other license physicians or dentist, concurring in the necessity of such surgery are obtained prior to the performance of surgery.

I understand medical information my be shared with appropriate school personnel as deemed necessary by the school administrator.

Physicians Name _____ Phone# _____

Dentist Name _____ Phone# _____

_____ _____
Date Signature of Parent/Guardian

REFUSAL TO CONSENT

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

_____

_____

Gallia County Local Schools District
Confidential History Form

TODAY'S DATE _____ SCHOOL ENROLLING TODAY _____

STUDENT'S NAME: LAST _____ FIRST _____ MIDDLE _____

CURRENT GRADE: _____ DATE OF BIRTH _____/_____/_____ GENDER: M F

MOTHER'S NAME _____ PHONE: _____

FATHER'S NAME _____ PHONE: _____

CHILD LIVES WITH: MOTHER FATHER GRANDPARENT GUARDIAN OTHER _____

CHILD'S PRIMARY ADDRESS: _____

SIBLINGS AND AGES: _____ _____

_____ _____

DOES YOUR CHILD HAVE: IEP YES NO 504 PLAN Y N SPECIAL EQUIPMENT Y N

DOES YOUR CHILD HAVE ALLERGIES (FOOD, MEDICATIONS, INSECTS, LATEX, ETC)? Y N

IF YES, PLEASE LIST ALLERGY AND TREATMENT _____

_____

Please list any medications/treatments this student requires daily (even if not needed at school): _____

_____

CHECK ANY OF THE FOLLOWING THAT APPLY TO THIS STUDENT:

☐ No Health Conditions	☐ Vision Impairments	☐ Digestive Issues	☐ MusculoSkeletal Issues
☐ ADHD/ADD	☐ amblyopia	☐ Eating Disorder	☐ Cystic Fibrosis
☐ Asthma	☐ wears glasses/contacts	☐ Menstrual Issues	☐ Mental Health Concerns
☐ Migraines/Headaches	☐ color vision deficits		☐ Learning Disabilities
☐ Diabetes	☐ Cardiac Issues	☐ Kidney Issues	☐ Hearing Issues
☐ Seizures	☐ High Blood Pressure	☐ Vascular Issues	☐ Liver Issues ☐ Hearing Aides R L

If you checked any of the above boxes, please describe the condition and current treatments:

_____

If this student has had accidents or surgery, please list the dates and nature of each:

_____

Please list any concerns not already listed that the school nurse/teacher need to address:

_____