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:

_____

Gallia County Local Schools District
Confidential History Form

I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact their learning.

I understand that for the safety of my student, or to provide for their educational achievement, the school nurse may need to share information about my child with the appropriate school staff and/or associated agencies. Under the regulations of FERPA (Family Education Rights and Privacy Act of 1974), this information shall be shared in confidential manner only as necessary. If I do not want information shared, I must request this in writing and file this request with the school nurse.

In order for a child to receive over the counter medication (such as Tylenol, Motrin), the parent/guardian will be contacted for permission to administer. Prescription medications, including inhalers and EpiPens, require completion of GCLS Authorization to Administer form by your physician and specific procedure for administering medication at school. Please ask for appropriate forms if needed.

This written validation will be in effect until otherwise noted or changed.

Signature of Parent/Guardian: _____ Date: _____

Southern Ohio Digital Academy

Student's Name: _____

You must provide a working email and telephone number for communication.

Working Email

Student:_____@_____._____

Parent: _____@_____._____

Primary phone #: _____

Attendance/ Hours Policy

The SODA week runs from Sunday through Saturday. SODA attendance is based upon hours that a student accumulates while completing school work. SODA requires a minimum of 30 hours of school work, each week. This includes completing courses online through Edmentum (or other instructional websites, as assigned) and staying up-to-date with assignments and passing grades. There is no exception to the 30 hours per week rule. Some students may need to work more than 30 hours to stay up-to-date on assignments, but are not allowed to do less. Any supplemental hours (instructional time not spent online) must be submitted by 11:59 pm on Saturday to count for that calendar week. Truancy violations will follow the student, regardless of building assignment.

Southern Ohio Digital Academy

General Guidelines:

1. You are required to complete a total of at least 920 blended hours per school year. Students are required to log 6 or more hours per day, a minimum of five days a week. This can be any day of the week. You can receive credit for no more than 10 hours a day.
2. If for any reason you feel that you will meet the qualifications needed for the use of a doctor's excuse, please contact Lori Bevan within 2 days of the need to discuss the possibility.
3. Failure to have internet is not an excuse. If your internet is down, you need to secure internet from another location; including the SODA Center in University of Rio Grande's Allen Hall.
4. The software that is being used is quite rigorous. The program is not likely to be suitable for students who have trouble completing school work. Additionally, SODA is not the least restrictive environment for students enrolled in special education courses and is not recommended for them.
5. Technical Issues: Please email gl_lbevan@gallialocal.org and explain the problem.

Consequences of not completing weekly hours, maintaining adequate progress:

1st Offense: Email to parent/caregiver including time logged and weekly deficit. Hours are to be made up, in addition to the 30 required for that week.

2nd Offense: Email to parent/caregiver including time logged and weekly deficit and phone call will be made to follow up. Hours are to be made up, in addition to the 30 required for that week.

3rd Offense: Email to parent/caregiver including time logged and weekly deficit. A meeting with the SODA team, and possibly the attendance officer, will be arranged with both the parent/guardian and student attending. The meeting will be via Google Meet/Zoom/telephone conference or in person to develop a plan to stay in the program. The plan will address the deficit hours, grades and/or progress in classes, depending on the individual student's needs to be successful. If the plan is not followed, the student may be removed from the program and enrollment will be transferred back to the traditional building.

4th Offense: Email to parent/caregiver including time logged and weekly deficit. The student may be removed from the program and enrolled/transferred back to the traditional building.

Southern Ohio Digital Academy

Course Breakdown

1 semester Course/ Quarterly Completion	Percentage Completion	Quarters	Yearly Course/ Quarterly Completion	Percentage Completion
½	50%	1st Quarter	¼	25%
1	100%	2nd Quarter	½	50%
		3rd Quarter	¾	75%
		4th Quarter	1	100%

***Must maintain a combination of at least 30 hours per week working in the online program and/or on supplemental work.**

Southern Ohio Digital Academy

Attendance Procedures, Policies and Consequences

Students

___ I understand that I must secure and have access to a computer with an internet connection to complete my school work.

___I understand that additional school supplies may be required for each subject. It is the obligation of the student (parent) to obtain those items.

___I will ask my teacher for assistance if I do not understand the concept, assignment or anything associated with the course. I will also answer any communication, in a timely manner, from SODA staff.

Parents/Guardians

___I understand that if my child is not completing the required hours and/or making adequate progress my child will likely be reported for truancy, and I will place myself in a situation where I have to work with the truancy officer to correct the problem.

___I understand that I will need to answer any correspondence from SODA staff in a timely manner.

___I understand that if my child is eligible for special education he/she will be assigned an intervention specialist that I can communicate with and understand that I need to attend yearly IEP meetings for my child.

___ I understand that if my child is in special education, he or she will be required to attend Google meets and in-person visits, as determined by the intervention specialist based upon the specifications outlined in the IEP.

___I understand that I must keep all personal information updated with SODA staff.

___I understand that all shot records need to be up-to-date and presented to SODA staff in a timely manner.

___I understand that full participation in all mandated state testing is expected and that my child must present himself or herself at the testing sites on the required dates (to be determined).

___I understand that SODA courses are not National Collegiate Athletic Association (NCAA) approved.

_____ _____

Print Student Name Student Signature

_____ _____

Parent Signature Date
(Required for students under 18)

_____ _____

SODA Representative Date