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

REQUEST FOR ENROLLMENT RECORDS

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

Please release the following records:

All standardized/state test/ACT scores *Copy of birth certificate and social security card*
*Current health/immunization records and **physical*** *Current schedule with current alpha/numerical grades*
Custody or court documents with school district education cost responsibility
UP TO DATE and SIGNED psychological reports, IEP, special education, and gifted records
Student's Ohio SSID# *Up to date transcript from **ALL** previous attended schools*

Previous School_____ Previous School District_____
I release _____ from any legal liability for giving information to GCLS by singing this form.
Address_____ City_____ State_____ Zip_____

Phone_____ Fax_____ Previous School IRN#_____

GCLS Building to attend_____
Student attended AE____HTE____RVHS____RVM____SGHS____SGM____SWE____VE____SODA____

Primary Language_____ Native Language_____ SSN_____/_____/_____

Race/Ethnicity White____Black/African American_____Asian_____American Indian/Alaskan Native_____
Native Hawaiian/Pacific Islander_____Hispanic/Latina_____Other_____

Special Programs ETR___IEP___ Disability_____ 504 Plan___ Birth City/State_____,_____

Court/Foster Place___ Court Documents___ School District responsible for education_____

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

I release GCLS and its staff from any legal liability for disclosing or acquiring information which I have permitted by signing this form.

_____ ___/___/___
Parent/Guardian Signature Date

Penny Coon
Administrative Assistant
gl_pcoon@gallialocal.org
Ext 10012

DATE ENTERED BUILDING/LOGGED ON / /

Gallia County Local Schools

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TB SKIN TESTING

In conjunction with The Gallia County Health Department, all new to Gallia County incoming students are required to have a TB Skin Test within the past twelve (12) months.

This test is mandatory **WITHIN FOURTEEN (14) DAYS** of GCLS enrollment. TB Skin Test are administered, free of charge, Monday, Tuesday, Wednesday, and Friday, 8:00 AM to 4:00 PM at the Gallia County Health Department, 499 Jackson Pike, Gallipolis, OH 45631, 740-441-2950.

After TB Skin Test is administered and read, documentation must be forwarded to the student's school for record keeping purposes.

NEW STUDENT BUS BOARDING PASS-*NOT CCO APPLICABLE*

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

CONFIDENTIAL HEALTH HISTORY
GALLIA COUNTY LOCAL SCHOOLS

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
- ☐ ADHD/ADD
- ☐ Asthma
- ☐ Migraines/Headaches
- ☐ Diabetes
- ☐ Seizures
- ☐ Cardiac Issues
- ☐ High Blood Pressure
- ☐ Vision Impairments
  - ☐ amblyopia
  - ☐ wears glasses/contacts
  - ☐ color vision deficits
- ☐ Hearing Impairments
  - ☐ Hearing Aides R L
- ☐ Eating Disorder
- ☐ Menstrual Issues
- ☐ Digestive Issues
- ☐ Cystic Fibrosis
- ☐ MusculoSkeletal Issues
- ☐ Kidney Issues
- ☐ Learning Disability
- ☐ Mental Health Concerns
- ☐ Liver Issues
- ☐ Vascular Issues

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:

_____

**Please Continue on Reverse Side

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: _____

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:

_____

_____