VALLEY VIRTUAL
REMOTE LEARNING ACADEMY

7320 N. Palmyra Road, Canfield, Ohio 44406
(330) 533.8755 ext. 1181 Fax (330) 533.8777

22+ Program Enrollment Form

Last Name _____ First Name _____ Middle _____

Maiden Name _____ SSN _____

Date of Birth _____Age _____ Place of Birth (city /state)_____

Male _____ Female _____

Address _____

Email _____ Phone _____

Ethnicity: **Asian ___ Black ____ Hispanic ___ Non-Hispanic ___ Multi-racial ____ White ____ Am. Indian _____Other _____**

School History

Last School Attended_____

Address of School _____

Date Last Attended _____Current Grade _____

Resident School District _____

IEP / ETR: Complete only if you were previously identified as a student with a disability and were provided special education services based on an IEP by a previous school district.

Identified Disability (as listed on IEP) _____

Date of most recent IEP _____

Student's Signature _____ Date _____

Documents Required with this Application

- Birth Certificate
- Driver's License / State Issued I.D.
- 2 Proof of Residency (ex: utility bill showing name, address and current date)

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22+ Emergency Medical Authorization

Section 3313.712, ORC

Student Name _____

Spouse / Partner's Name _____

Address_____

Phone _____

In case of emergency, contact:

Name _____ Phone _____

Name _____ Phone _____

Part I - TO GRANT CONSENT

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

Hospital _____

Doctor _____ Phone _____

Dentist _____ 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 doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician; and (2) the transfer of the child to any hospital reasonable accessible.

This authorization does not cover major surgery unless the medical opinions of two other physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

_____

Date _____ _____

Student's Signature

1. Any health problems or concerns that school personnel should be aware of:

2. Are you under doctor's care on an ongoing basis?

3. Allergies - medicine, food or environmental? Please specify.

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Request for Transcript - 22+ Program

Please send transcripts to: s.forsythe@valleyvirtual.org
or fax to 330.533.8777

TO: *(previous school name)* _____

The following student is enrolling in MCESC / Valley Virtual Remote Learning Academy 22+ Diploma Program.

Name _____Maiden Name _____

Last Year Attended _____ Grade _____

Date of Birth _____

__X__STUDENT TRANSCRIPT

__X__STATE TESTING RESULTS

__X__IEP / ETR / ANY SPECIAL NEEDS INFORMATION

I understand that my signature on this form authorizes the named school to send my transcripts to Valley Virtual Remote Learning Academy for the 22+ Diploma program.

Student Signature _____ Date _____

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