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 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:** _____

EMERGENCY MEDICAL STUDENT AUTHORIZATION FORM

SCHOOL_____ DATE_____ GRADE_____

STUDENT NAME_____

HOME ADDRESS_____
PO BOX STREET/ROAD CITY STATE 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_____

MOTHER's 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 IN THE HOME (who are under the age of 19 or enrolled in a building/school in our district):

LAST NAME	FIRST NAME	GRADE	AGE

PLEASE LIST IN ORDER, PEOPLE TO BE CONTACTED in event child needs to be released to other than caregiver (Guardian will be contacted first unless stated otherwise)

NAME	RELATIONSHIP	HONE PHONE	CELL PHONE

MEDICAL HISTORY TO WHICH A PHYSICIAN SHOULD BE ALTERED
(Allergies, Physical Impairment, Medications being taken, etc.)

_____

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

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

PHYSICIAN'S NAME_____ PHONE_____

DENTIST NAME_____ PHONE_____

_____ _____

DATE SIGNATURE OF GUARDIAN

REFUSAL TO CONSENT

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

_____