DIGITAL ACADEMY

South Central Ohio Educational Service Center

Student Information

Name_____ **Gender** _____**Male** _____**Female**
Last **First** **Middle**

Name student wishes to be called _____ **Date of Birth** _____/_____/_____

Place of Birth _____ **Social Security Number** _____
City **State** **County**

Phone _____ **Cell Phone** _____

Address _____

Student Race ***(Circle)***

White Asian Black or African American American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander Hispanic or Latino

Parent Information

Mother's Name _____**Maiden Name**_____

Address _____

Phone _____ **Email**_____

Occupation _____ **Employer**_____

Father's Name _____

Address _____

Phone _____ **Email**_____

Occupation _____ **Employer**_____

By signing below, you, the parent/guardian, understand that your child, if in grades 6-12, will be required to attend the SCOESC Digital Academy at least on their scheduled day (one day a week). You also understand that progress in ALL subjects must be maintained or extra days of in person attendance will be required. In addition, children enrolled in the K-5 program will participate in scheduled online classes and are required to attend at those scheduled times. Attendance and progress will be monitored in all grades and will be addressed accordingly. Finally, by signing below the parent/guardian is affirming that the student will have adequate access to the internet in order to complete classes when not in attendance on campus.

Parent Signature_____ **Date**_____

School District Information

District Representative Name _____ **Position** _____

District IRN _____ **Building IRN** _____ **SSID** _____

Current Student Status (all that apply):

Active Good Standing, Truancy Issue, Grade Level on Target, IEP, Credit Deficiency, RIMP .

First semester courses*	Second semester courses*

***For Middle School and High School (Grades 6-12)**

District Representative Signature_____ **Date**_____

DIGITAL ACADEMY

South Central Ohio Educational Service Center

EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority

Student's Name _____ **Grade** _____ **Birth date** _____

Mailing Address _____

Telephone ( ) _____ **Home E-Mail Address** _____

Residential Parent or Guardian

Mother's Name_____ **Home/Cell Phone Number** _____ **Work Number**_____

Father's Name_____ **Home/Cell Phone Number** _____ **Work Number**_____

Additional Contact_____ **Home/Cell Phone Number** _____ **Work Number**_____

Additional Contact_____ **Home/Cell Phone Number** _____ **Work Number**_____

Medical Conditions and Medications to be taken at school.

(New prescription form must be on file each school year)

1) _____ _____
Condition **Prescription**

2) _____ _____
Condition **Prescription**

PART I: TO GRANT CONSENT

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

Physician_____ **Phone ( ) _____**

Dentist_____ **Phone ( ) _____**

Medical Specialist_____ **Phone ( ) _____**

Local Hospital Preference_____

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-name doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

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

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

_____

Date _____ **Signature of Parent/Guardian**_____

PART II: REFUSAL TO CONSENT

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

_____

Date _____ **Signature of Parent/Guardian**_____

DIGITAL ACADEMY

South Central Ohio Educational Service Center

Permission to Share Student Information

Student _____ Date of Birth _____

I give my permission for the following individuals/agencies to share information about my child:

_____ Local School District
South Central Ohio Educational Service Center (includes SCOESC Digital Academy & CAPE)

These agencies listed above will be partnering to provide comprehensive preschool services in the SCOESC Digital Academy. In order to best serve your child we may need to share the following information:

Enrollment Information
Special Education Records
Progress Notes/ Reports
Attendance Records
Test Scores / Screeners

Beginning Date _____

Ending Date _____
(All permission ends automatically at the end of the current school year, unless otherwise indicated)

Parent/Guardian Signature _____

Date _____

Permission rescinded on _____ Signature _____

DIGITAL ACADEMY

South Central Ohio Educational Service Center

STUDENT RELEASE AUTHORIZATION

(Non Medical)

The below listed individuals may pick up my child from school. They will follow regular early dismissal procedures and may be asked to present picture identification. This is not a release for medical (accident or illness) reasons, but a courtesy to parents who may need to have other individuals get the child from school. Medical release information is listed on the Medical Authorization Form.

Name	Relationship	Telephone Number
1.		
2.		
3.		
4.		
5.		

Parent/Guardian Signature _____

Date _____