720 Payne Ave
Saint Paul, MN 55130
Phone: (651) 796-4500
Email: contact@hope-school.org
www.hopecommunityacademy.org

Student Information

☐ **New Student**

☐ **Returning Student, HOPE Student ID:**_____

Child's Legal Name: _____ _____ _____
Last First Middle

Gender: ☐ Male ☐ Female DOB: ____/____/____ Did this child attend Preschool: ☐ Yes ☐ No (KG ONLY)
MM DD YYYY

Age (on the date of registration): _____ Check one: ☐Current School Year ☐Next School Year

Registering for grade (circle one): Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12

School last attended: _____ _____
Name of School City and State

Racial/Ethnic Group:
☐ African American ☐ American Indian
☐ Asian / Pacific ☐ Caucasian
☐ Latino ☐ Other: _____

Student has an IEP: ☐ Yes ☐ No ☐ Unknown

Student has ELL services: ☐ Yes ☐ No ☐ Unknown

Immigration Information:

Place of Birth: _____
City State Country

Immigrant? ☐Yes ☐No Arrival into US: _____
Month Year

Siblings Currently Attending HOPE Community Academy

Name: _____ Grade: ____ Name: _____ Grade: ____

_____ _____
Parent/Guardian's Signature Date

Please Send Application to: HOPE Community Academy
720 Payne Ave
Saint Paul, MN 55130
P: 651-796-4500 F: 651-927-8481

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HOPE Community Academy
Enrollment Form

Parents/Guardians

List All New Students' Name:

_____

_____

Child(ren) lives with: ☐Both Parents ☐Father ☐Mother ☐Other: _____
Name Relationship

Who is the primary contact person for this student?

☐ Father/Step-Father ☐ Mother/Step-Mother ☐ Other

Household Address:

_____
Street Name Apt/Unit #

_____
City State Zip code

Parent/Guardian 1 Name:_____
First Name Last Name

Relationship to Student: ☐Father/Step-Father ☐Mother/Step-Mother ☐Other: _____
Relationship

Does the parent need an interpreter? ☐Yes ☐No What is the preferred language?_____

Home Phone:_____ Cell Phone: _____ Work:_____

E-mail:_____

Parent/Guardian 2 Name:_____
First Name Last Name

Relationship to Student: ☐Father/Step-father ☐Mother/Step-mother ☐Other: _____
Relationship

Does the parent need an interpreter? ☐Yes ☐No What is the preferred language?_____

Home Phone:_____ Cell Phone: _____ Work:_____

E-mail:_____

Alternative Address (if applicable):

_____
Street Name/PO BOX Apt/Unit #

_____
City State Zip code

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Emergency Contacts

In case of an emergency the school will attempt to contact you. If the school is unable to do so, please provide us with the names of three persons who we may contact to care for your child. Inform them that you have provided the school with their names.

☐Household ☐Non-Household

Name: _____ Gender: ☐ Male ☐ Female

Telephone: _____ Relationship: _____

☐Household ☐Non-Household

Name: _____ Gender: ☐ Male ☐ Female

Telephone: _____ Relationship: _____

☐Household ☐Non-Household

Name: _____ Gender: ☐ Male ☐ Female

Telephone: _____ Relationship: _____

_____ _____

Parent/Guardian's Signature Date

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Reviewed by/date

☐Current / ☐Next School Year

Student Health Information/Concerns

Student Name: _____ **Birth Date:** _____ ☐ **Male** ☐ **Female** **Grade:** _____

Parent/Guardian: _____ **Phone: Home:** _____ **Work:** _____

Cell: _____

Dear Parent/Guardian:
Your child's health may affect his or her learning. Health information is important in planning for your child's needs at school. Your input and involvement are important. Please complete this form and return it to school as soon as possible.

HEALTH CONCERNS: Please X and explain if your child has any of the following:

Yes	No	
☐	☐	Attention Deficit Hyper-activity Disorder/Attention Deficit Disorder (ADHD/ADD)
☐	☐	Allergies* i.e. food/seasonal (to what? _____)
☐	☐	Has the allergy been diagnosed by a doctor? Medication for allergy: _____ ***Complete allergy action plan if appropriate***
☐	☐	Lactose Intolerance? Describe: _____
☐	☐	Asthma or other breathing problems: ***Complete asthma action plan if appropriate***
☐	☐	Has asthma been diagnosed by a Health Care Provider?
☐	☐	Currently has an inhaler?
☐	☐	Ever hospitalized for asthma? If so, when was the last hospitalization? _____
☐	☐	Other breathing problem (describe): _____
☐	☐	Diabetes: ❒ Type 1* ❒ Type 2 ***Must complete diabetes emergency plan.*** Managed by: ❒ Diet/Activity ❒Oral meds ❒ Insulin injections ❒ Insulin Pump
☐	☐	Heart Conditions: _____
☐	☐	Seizures: Date & type of last seizure: _____ ****If yes, must complete seizure action plan***
☐	☐	Has your child ever had a concussion or head injury?
☐	☐	Social/emotional/behavioral/mental health concerns: _____
☐	☐	Is there a current concern that your child has been a ❒ target / ❒ instigator of bullying?
☐	☐	Recent surgeries or hospitalizations: _____
☐	☐	Activity restrictions: _____
☐	☐	Receives Special Education /IEP/504 Services
☐	☐	Other health concerns: _____

EMERGENCIES: Does your child have a known health problem that could result in an emergency? ❒ **Yes*** ❒ **No**

Must complete emergency action plan

Please describe:

_____

_____

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MEDICATIONS

First, list ALL medications that your child takes:

_____

Now, list **ALL** medications that your child needs DURING THE SCHOOL DAY. An authorization with parent and health care provider consent is required each school year for all the following listed prescription **AND** over-the-counter medications***. A new consent is needed each school year.***

_____

Vision	**Hearing**
☐ Glasses/contacts prescribed	☐ Frequent ear infections (more than 3 per year in past year)
☐ Wears glasses/contacts all of the time	☐ Has ear tube(s)
☐ Wears glasses in classroom only	☐ Hearing loss ☐ right ear ☐ left ear
☐ Request assistance obtaining glasses	☐ Hearing aid(s) ☐ right ear ☐ left ear
☐ No vision problem	☐ No hearing problem

HEALTH INSURANCE:

My child has health insurance: ☐ Yes ☐ No

I request assistance with health insurance: ☐ Yes ☐ No

HEALTH CARE PROVIDERS:

Does your child have a doctor or clinic where they usually go for health care? ☐ Yes ☐ No
If yes, please complete the following:

_____ _____
Primary Health Provider **Location and Phone**

_____ _____
Dental Provider **Location and Phone**

_____ _____
Other **Location and Phone**

Hospital preference_____

I attest to the information provided and give permission for its release for confidential use in meeting my child's health and educational needs in school. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, and/or allergies.

Parent/Guardian signature _____ **Date:** _____

Print Parent/Guardian name: _____

Parent/Guardian email contact: _____

Comments:

_____

_____

_____

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested information—there will be no consequences—it may result in an incomplete health and safety plan for your child. The information you provide will be shared with those whose jobs require access to this information to ensure your child's safety and school success. (MS section 13.04, Subdivision2)

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Minnesota Language Survey

Minnesota is home to speakers of more than 100 different languages. The ability to speak and understand multiple languages is valued. The information you provide will be used by the school district to see if your student is multilingual. In Minnesota, students who are multilingual may qualify for a Multilingual Seal upon further assessment. Additionally, the information you provide will determine if your student should take an English proficiency test. Based upon the results of the test, your student may be entitled to English Language development instruction. **Access to instruction is required by federal and state law. As a parent or guardian, you have the right to decline English Learner instruction at any time.** Every enrolling student must be provided with the Minnesota Language Survey during enrollment. Information requested on this form is important to us to be able to serve your student. Your assistance in completing the Minnesota Language Survey is greatly appreciated.

Student Information	
Student's Full Name: (Last, First, Middle)	Birthdate or Student ID:

	Check the phrase that best describes your student:	**Indicate the language(s) other than English in space provided:**
1. My student first learned:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
2. My student speaks:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
3. My student understands:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
4. My student has consistent interaction in:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	

Language use alone does not identify your student as an English learner. If a language other than English is indicated, your student will be screened for English language proficiency.

Parent/ Guardian Information	
Parent/Guardian Name (printed):	
Parent/Guardian Signature:	Date:

*All data on this form is private. It will only be shared with district staff who need the information to best serve your student and for legally required reporting about home language and service eligibility to the Minnesota Department of Education. At the district and at the Minnesota Department of Education, this form will not be shared with other individuals or entities, except if they are authorized by state or federal law to access the information. Compliance with this request for information is voluntary.

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☐ New HOPE student ☐ Current HOPE student

Bus Pick-Up and Drop-Off

Please notify HOPE Community Academy of any changes to this information. We are unable to comply with changes to bus pick-up and drop-off instructions unless a revised form is completed, signed, and on file in our office.

Please complete one form for each child enrolled at HOPE.

Student name: _____ **Grade:** _____

Home Address

Pick-Up Street Address: _____

City, State, Zip: _____

Phone Number for this Address: _____

Alternative/Daycare Address (If Different From Home Address)

Pick-Up Street Address: _____

City, State, Zip: _____

Drop-Off Street Address: _____

City, State, Zip: _____

Phone Number for this Address: _____

Students who are experiencing homelessness have the right to attend the school of origin when first becoming homeless and are entitled to transportation to and from school.

_____ _____

Print Parent's/Guardian's Name **Parent's/Guardian's Signature** **Date**

For Office Use Only

Date Received/Requested:_____ ☐ IC Updated ☐ Regular ☐Homeless ☐SPED ☐Temporary

Date to Start:_____ AM Time:_____ AM Pick-up Location:_____

Bus/Van #:_____ PM TIme:_____ PM Pick-up Location:_____

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Parent Authorization

Student Name:_____ _____ **Grade**:_____
First Name Last Name

Media Release

During the school year, staff of HOPE Community Academy and media may want to interview, photograph or videotape your child for use in publications, television reports, and public presentations. The pictures may be of groups of students or individuals, but the students' names will not be used.

Please check ONLY ONE:

☐ Yes, I give *permission* to use my student's photo/video only in publications related to informing the public about and promoting enrollment at HOPE Community Academy. This permission will expire one year from the date of this consent.

☐ No, I do not give permission for my child to be photographed/videotaped at HOPE Community Academy.

Field Trip Permission

I understand my child may either walk or be bused to field trips during the school year.

I acknowledge that I will receive specific information for bussing relating to field trips prior to the actual date for parental approval. Transportation will be provided by a licensed bus service.

☐ Yes

Internet

I understand that students and families may be held liable for violations of the Internet Use Policy. I also understand that some materials on the Internet may be objectionable, but I accept responsibility for guidance of Internet use by setting and conveying standards for my daughter/son to follow when selecting, sharing, or exploring information.

☐ Yes

Parent/Guardian Name (please print):

_____ _____
First Name Last Name

Parent/Guardian Signature:_____ **Date**:_____