

### Student Information

☐ New Student or ☐ Returning Student (OFFICE ONLY) Hope Student ID# \_\_\_\_\_ (OFFICE ONLY) State ID# \_\_\_\_\_  
☐ Current School Year or ☐ Next School Year

Child's Legal Name: \_\_\_\_\_  
(per birth certificate) Last First Middle

Gender: ☐ Male ☐ Female DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Registering for grade: Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12  
MM DD YYYY

### Household Information

Child lives with: ☐ Both Parents ☐ Father ☐ Mother ☐ Other: \_\_\_\_\_  
Name Relationship

Household Address:

\_\_\_\_\_  
Street Name Apt/Unit #  
\_\_\_\_\_  
City State Zip code

### Parents/Guardians

Parent/Guardian 1 Name: \_\_\_\_\_  
Last Name First Name

Relationship to Student: ☐ Father ☐ 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: \_\_\_\_\_  
Last Name First Name

Relationship to Student: ☐ Father ☐ 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

**Additional Student Information****Student Services:**SPED/IEP: ☐ Yes ☐ No ☐ UnknownEL Services: ☐ Yes ☐ No ☐ Unknown**Place of Birth:**

City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

**Immigrant:** ☐ Yes ☐ No If Yes, Date of Arrival (MM/YYYY): \_\_\_\_ / \_\_\_\_**Previous School Information**

School Last Attended: \_\_\_\_\_

City/State: \_\_\_\_\_

Last day of attendance: \_\_\_\_\_

**Emergency Contacts**

*Other than parents/guardians. Please provide up to three contacts we can contact in case of emergency and we are unable to contact parents/guardians. Inform them that you have provided the school with their names.*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: ☐ Male ☐ Female  
Last Name First Name

Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: ☐ Male ☐ Female  
Last Name First Name

Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: ☐ Male ☐ Female  
Last Name First Name

Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Ethnic and Racial Designation Form

Schools are required to report student ethnicity and race to the State of Minnesota and the U.S. Department of Education. Recent changes in Minnesota law require more detailed categories to better represent our student populations. This information is private and used only to improve teaching, learning, and advocacy for underserved students. For details, see the Privacy Notice in the FAQ.

- **Federal questions** (in bold) are required. If parents/guardians do not answer, schools must select on their behalf.
- **State questions** are labeled Optional and will not be filled in by school staff.

### Federal Question

#### Is the student Hispanic/Latino?

Definition: Persons of Cuban, Mexican, Puerto Rican, South/Central American, or other Spanish culture or origin, regardless of race.

- Yes → *Optional Question A below*
- No

*Optional Question A (check all that apply):*

☐ Decline ☐ Colombian ☐ Ecuadorian ☐ Guatemalan ☐ Mexican ☐ Puerto Rican ☐ Salvadoran ☐ Spaniard/Spanish/Spanish-American ☐ Other ☐ Unknown

### Federal Questions 1–6 (Select “Yes” to at least one)

#### 1. **American Indian/Alaska Native (U.S.)**

- Yes → *Optional 1a* ◦ No
- Optional 1a (check all):* ☐ Anishinaabe/Ojibwe ☐ Dakota/Lakota ☐ Cherokee ☐ Other Tribal Affiliation ☐ Decline ☐ Unknown

#### 2. **Asian** (origins in Far East, Southeast Asia, Indian subcontinent)

- Yes → *Optional 3a* ◦ No
- Optional 3a:* ☐ Asian Indian ☐ Burmese ☐ Chinese ☐ Filipino ☐ Hmong ☐ Karen ☐ Korean ☐ Vietnamese ☐ Other ☐ Decline ☐ Unknown

#### 3. **Black or African American**

- Yes → *Optional 4a* ◦ No
- Optional 4a:* ☐ African-American ☐ Ethiopian (Oromo/Other) ☐ Liberian ☐ Nigerian ☐ Somali ☐ Other ☐ Decline ☐ Unknown

#### 4. **Native Hawaiian/Other Pacific Islander**

- Yes ◦ No

#### 5. **White** (origins in Europe, Middle East, or North Africa)

- Yes ◦ No

## 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.

	Check the phrase that best describes your student:	Indicate the language(s) other than English in space provided:
1. My student first learned:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
2. My student speaks:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
3. My student understands:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> only English.	
4. My student has consistent interaction in:	<input type="checkbox"/> language(s) other than English. <input type="checkbox"/> English and language(s) other than English. <input type="checkbox"/> 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.

## Student Digital Equity Survey

1. Does the student use an electronic device (computer, tablet, smartphone) to complete homework?

- ☐ No → Skip to Q2  
☐ Yes → Continue to 1a

1a. What type of device is usually used? (select ONE)

- ☐ Desktop/Laptop  
☐ Tablet  
☐ Chromebook  
☐ Smartphone  
☐ Other

1b. Is the device provided by the school? ☐ Yes ☐ No

1c. Is the device shared with others in the home?

- ☐ Yes ☐ No

2. Can the student access the Internet at home?

- ☐ No – Not available (End survey)  
☐ No – Not affordable (End survey)  
☐ No – Other (End survey)  
☐ Yes → Continue to 2a

2a. Type of Internet service at home:

- ☐ Residential broadband (Cable/Fiber/DSL) ☐ Cellular  
☐ Hotspot (school) ☐ Satellite ☐ Dial-up ☐ Other  
☐ Not sure

2b. Can the student stream video without pauses?

- ☐ Yes-no pauses ☐ Yes-some pauses  
☐ No – doesn't work

## Parent Authorization

**Student name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

### 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 Information

Parent/Guardian Name (printed):

Parent/Guardian Signature:

Date:

## 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	
<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit Hyper-activity Disorder/Attention Deficit Disorder (ADHD/ADD)
<input type="checkbox"/>	<input type="checkbox"/>	Allergies* i.e. food/seasonal (to what? _____)
<input type="checkbox"/>	<input type="checkbox"/>	Has the allergy been diagnosed by a doctor? Medication for allergy: _____ <b>*Complete allergy action plan if appropriate</b>
<input type="checkbox"/>	<input type="checkbox"/>	Lactose Intolerance? Describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or other breathing problems: <b>*Complete asthma action plan if appropriate</b>
<input type="checkbox"/>	<input type="checkbox"/>	Has asthma been diagnosed by a Health Care Provider?
<input type="checkbox"/>	<input type="checkbox"/>	Currently has an inhaler?
<input type="checkbox"/>	<input type="checkbox"/>	Ever hospitalized for asthma? If so, when was the last hospitalization? _____
<input type="checkbox"/>	<input type="checkbox"/>	Other breathing problem (describe): _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: <input type="checkbox"/> Type 1* <input type="checkbox"/> Type 2 <b>*Must complete diabetes emergency plan.</b> Managed by: <input type="checkbox"/> Diet/Activity <input type="checkbox"/> Oral meds <input type="checkbox"/> Insulin injections <input type="checkbox"/> Insulin Pump
<input type="checkbox"/>	<input type="checkbox"/>	Heart Conditions: _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures: Date & type of last seizure: _____ <b>*If yes, must complete seizure action plan</b>
<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever had a concussion or head injury?
<input type="checkbox"/>	<input type="checkbox"/>	Social/emotional/behavioral/mental health concerns: _____
<input type="checkbox"/>	<input type="checkbox"/>	Is there a current concern that your child has been a <input type="checkbox"/> target / <input type="checkbox"/> instigator of bullying?
<input type="checkbox"/>	<input type="checkbox"/>	Recent surgeries or hospitalizations: _____
<input type="checkbox"/>	<input type="checkbox"/>	Activity restrictions: _____
<input type="checkbox"/>	<input type="checkbox"/>	Receives Special Education /IEP/504 Services
<input type="checkbox"/>	<input type="checkbox"/>	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: \_\_\_\_\_

\_\_\_\_\_

## **MEDICATIONS**

First, list ALL medications that your child takes:

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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.***

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### **Vision**

- ☐ Glasses/contacts prescribed
- ☐ Wears glasses/contacts all of the time
- ☐ Wears glasses in classroom only
- ☐ Request assistance obtaining glasses
- ☐ No vision problem

### **Hearing**

- ☐ Frequent ear infections (more than 3 per year in past year)
- ☐ Has ear tube(s)
- ☐ Hearing loss ☐ right ear ☐ left ear
- ☐ Hearing aid(s) ☐ right ear ☐ left ear
- ☐ 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 \_\_\_\_\_

Phone \_\_\_\_\_

Dental Provider \_\_\_\_\_ Location \_\_\_\_\_

Phone \_\_\_\_\_

Hospital preference \_\_\_\_\_ Location \_\_\_\_\_

Phone \_\_\_\_\_

**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:**

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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)

☐ 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:** \_\_\_\_\_ **BUS / VAN #:** \_\_\_\_\_ AM Pick-up Time: \_\_\_\_\_ Location: \_\_\_\_\_

**BUS / VAN #:** \_\_\_\_\_ PM Drop-off Time: \_\_\_\_\_ Location: \_\_\_\_\_

(circle one)