**Application for Enrollment**

**Mettle Services**

4661 Sawmill Road

Columbus, Ohio 423220

Phone:614-270-3110 Fax: 614-456-7721

Student Name: \_ Parent Contact Name: \_ Student Current Grade Level: School Currently Attending: \_ Email: Phone:

Instructions:

In order to begin the enrollment process Mettle Services needs the following information:

1. A completed Autism Student Funding Application
2. A current copy of the child's IEP
3. A current copy of the child's ETR
4. A copy of the child's birth certificate
5. A proof of address (this can be a copy of an electric bill, gas bill, or water bill)

If you have any questions please call

614-270-3110

**STUDENT'S AGREEMENT**

Every student, regardless of age, must read and sign below:

I have read, understand, and agree to abide by the terms of the Acceptable Use and Internet Safety Policy of the Mettle Services. Should I commit any violation or in any way misuse my access to the School District's computer network and the Internet, I understand and agree that my access privilege may be revoked and School disciplinary action may be taken against me.

Student name Home Phone

Address

Address

User (place an "X" in the correct blank): I am 18 or older I am under 18 \_.

If I am signing this Agreement when I am under 18, I understand that when I turn 18 this Agreement will continue to be in **full** force and effect, and I will continue to abide by the Acceptable Use and Internet Safety Policy.

**STUDENT REGISTRATION FORM**

|  |  |  |
| --- | --- | --- |
| Students Name IDate of Birth | Current Age | Gender |
| Grade EnteringILast Grade CompletedILast School Attended | | City of Last School Attended |
| Current Address of Residency  I | | |
| County of Student's Residence School District of Student's Residence | | Is this Child a Ward of the State? |
| Mother's Last Name | City in which the Child was born | |
| Student Live with | Person with Legal Custody | |
| Brothers Name (if any) | Sisters Name (if any) | |

**PARENT INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Parent or Guardian Name |  |  | I | Relationship |
| !Address |  |  |  |  |
| Home Phone |  | Cell Phone |  | Work Phone |
| Email |  |  |  |  |
| Parent or Guardian Name |  |  |  | Relationship |
| !Address | | | | |
| Home Phone | I | Cell Phone |  | ICell Phone |
| Email | | | | |

### Consent for Release of Student Records

To Whom It May Concern:

The student named below has registered at Mettle Services

Please release the records for:

**Student Name Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Grade Level School Name School District Name**

**School Address**

**School Phone School Fax**

Please forward the records identified below to:

Mettle Services

Attn:Student Records

4661 Sawmill Road

Columbus.Ohio 43220

I authorize the release of records including IEP and ETR records for the above named student.

**Parent Signature Date \_**

Please forward the following records:

Birth Certificate

Immunization records

Transcript of all grades and credits Ohio Proficiency Test Results Behavior Reports/Assessments Attendance Records

Adoption/Custody Papers (if applicable) IEP and ETR Records (if applicable)

Withdrawal Grades and Credits Received Standardized Test Results

Speech Therapy Health Records

Psychological Report (if applicable) Vocational Evaluations

(if applicable)

If records are not available, please return this request indicating the following No Records

Available Reason(s)

Unable to send

Records Reason(s) \_

If you have any questions please call us at 614-270-3110

\*\* Written consent for release is no longer required when records are requested by authorized school

personnel. (Education Amendments of 1974, "Protection of the Rights and Privacy of Parents and Students" Section 438, Subsections (b) Parts A and B page 97).

**Student Withdraw Request Form**

I would like to officially withdraw who is in the (Student Name)

from effective immediately. Current Grade (School Name)

School Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Phone:

I am enrolling the above named student at Mettle Services

Name of Parent

Address:

Parent Signature Date \_

**Date: Student Name:**

**Address:**

**Birthday:**

**Home Phone: Cell Phone: \_ School Messenger Phone: \_**

(The one number you would like to be contacted for the following: notification of absence, closings or delays, or various situations.)

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parents:** D **Married** D **Divorced** □**Separated** D **Other, Please specify:** \_

**If divorced/separated/other, who is residential parent?:**

**Name of non-residential parent:**

**Address of non-residential parent:**

**Purpose** - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, or non-emergency incidents when parents or guardians cannot be reached.

**Mother/Guardian Name: \_ Home Phone: Father/Guardian Name: \_ Home Phone:**

**Other's Name: \_ Home Phone: \_**

Cell Phone: \_ Work Phone: \_ Cell Phone: Work Phone: \_

Cell Phone:

Work Phone: \_

**Please list facts concerning the child's medical history, including allergies, medication being taken, and any physical impairment to which a physician should be alerted.**

**Allergies (Please list all allergies, type of reaction, and treatment): \_**

**Medical Condition(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Medications/Treatments**:**

Does your child have any condition that could be life threating? **Check One:** D Yes D No

If YES, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION AUTHORIZATION: Dispensing Over the Counter Medication at School.**

* **Please check if authorized to give out medication:**

**Please select approved medications to give out:**

□Acetaminophen (Tylenol) 650 mg □Ibuprofen (Advil) 400 mg □Calcium Carbonate (Tums)

* **Please check if NOT authorized to give out medication**

I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable and unforeseeable for damages or injury resulting directly or indirectly from this authorization.

**Signature of Parent/Guardian Date**

**COMPLETE ONLY ONE OF THE FOLLOWING (SECTION** I OR II):

SECTION I: Consent for Treatment

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

**Do you have a primary care physician? (Check one)**

□Yes □No

**If so, have you seen your primary care physician in the last year? (Check one)** □ Yes □No

**If you do not have a primary care physician, can the school refer you to one? (Circle one)** Yes No

**Preferred Physician Office Phone**

**Preferred Dentist Office Phone**

**Preferred Eye Specialist Office Phone**

**Medical Specialist Office Phone**

**Preferred Hospital ER Phone**

**Record of last Tetanus Shot**

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 or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

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

Signature of Parent Date

**DO NOT COMPLETE SECTION** II **IF YOU COMPLETED SECTION** I.

SECTION 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 for the school authorities to take the following actions:**

Mettle Services Field Trip Permit

The student has my permission to participate in trips to various locations as part of the instructional/ co-curriculum activities during the school year.

Signature of Parent /Guardian Date

### IMMUNIZATION EXEMPTION FORM

In accordance with the Ohio Revised Code - Amended Section 3313.671 (Part A), I hereby request that

**Name of Student**

**Date of Birth**

Be exempt from school immunizations. I understand that due to the lack of immunizations, should any epidemic or communicable disease outbreak occur, the above named student may be excluded from attendance at all school functions in which other students are present.

Signature of Parent Date

Mettle Services

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY Mettle PERSONNEL

No medication that is prescribed by physician for a student shall be administered to that student unless:

1. The designated personl receives a written request, signed by the parent, guardian, or other person having care or charge of the student, that the drug be administered to the student.
2. The signed statement that is presented to the designated person shall include the following information:

Name of Student Address

Is under my care and should receive-------::-:---:-::------:c ­

<Name of Drug, Dosage)

The following times

Specific instructions for administration (if any)

Common or usual side effects to watch for (if any)

The date the administration of the drug is to begin

Physician's Signature

Phone number where the physician can be reached if emergency

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY METTLE PERSONNEL

I hereby request and give my permission to the director or a delegate to administer the following medication to my child.

Name of Child

Name of Drug

Dosage.

Administer at the following times

Signature of Parent Date

Phone number of Parent/Guardian \_