



LAUNCH

Expeditionary Learning Charter School

STUDENT ENROLLMENT FORM

I. STUDENT INFORMATION

Student Name (Last, First, MI)

OSIS Number

Street Address

Date of Birth

Place of Birth

City

State

Zipcode

Home Phone

Gender

Male

Female

Grade Entering

Name of Most Recent School Attended

Homeschooled?

Yes

No

Student lives with (check all that apply):

Father

Mother

Stepfather

Stepmother

Grandmother

Grandfather

Foster Parents

Other (Please Specify) _____

Temporary or Transitional Housing

Race/Ethnic Background:

American Indian

African American

Asian American

Hispanic

White

Other (Please Specify) _____

II. FAMILY INFORMATION

Mother/Guardian

Name of Mother/Guardian

Mother/Guardian Social Security Number

Mother/Guardian Street Address

Apt

City

State

Zip

Mother/Guardian Primary Phone

Mother/Guardian Secondary Phone

Mother/Guardian Email

Mother/Guardian Employer

Mother/Guardian Work Phone

Father/Guardian 2

Name of Father/Guardian 2

Father Social Security Number

Father/Guardian 2 Street Address

Apt

City

State

Zip

Father/Guardian 2 Primary Phone

Father/Guardian 2 Secondary Phone

Father/Guardian 2 Email

Father/Guardian 2 Employer

Father/Guardian 2 Work Phone

Please list other children (e.g. siblings) living in the child's home (optional):

Name

Age

Present School

Grade

Name

Age

Present School

Grade

Name

Age

Present School

Grade

Name

Age

Present School

Grade

IV. OTHER INFORMATION

PARENTAL INVOLVEMENT

Launch believes in the value of parental involvement in the education of children, and would like to ask parents to commit to several hours of volunteer work over the course of the school year.

Are you available to volunteer at the school? Yes No

If yes, how would you like to contribute?

HOW DID YOU HEAR ABOUT LAUNCH CHARTER SCHOOL? (check all that apply)

Direct Mail/Postcard Word of Mouth Internet I passed by the school A Flier

Newspaper Other (Please Specify): _____

SPECIAL EDUCATION SERVICES*

Please check any of the following services that your child receives.

- Special Education – Integrated Classroom
- Special Education – Small Classroom
- Speech Therapy
- Physical Therapy
- Occupational Therapy

*If your child has an Individualized Education Plan, please submit a copy to the school ASAP.

TRANSPORTATION PREFERENCE

Please indicate your preference for your child’s daily transportation to school. Students at Launch are eligible for *Metrocard* service in accordance with Department of Education policies. Please note that *MetroCard* eligibility is determined by the Department of Education.

- Subway/City Bus (Metrocard) Walk to school I decline transportation services for 2012-13. I understand that I may request transportation services at any time.

MEDIA RELEASE

Launch Expeditionary Learning Charter School will make an effort to promote the activities, honors, and work of our staff and students as well as the philosophy and vision of the school. This includes our school newsletter, website, Facebook page, and promotional materials such as brochures and fliers. There will be opportunities for various students to be interviewed and/or photographed and identified by name in the media and publications described above. However, we understand that some parents may request that we do not identify their child(ren). Please fill out the form below to inform us of your wishes regarding publicity.

IN NO CASE will Launch allow an outside organization, individual, or media group to contact students or use student photos, names, interviews, or any student work without prior, written consent from the parent/guardian of the child.

- I give permission for my child to be interviewed, identified, and/or photographed/filmed for use in various **school publications and media only**, including, but not limited to, the school website and Facebook page and school brochures, newsletters, and videos.
- I request that you do not interview or photograph my child.
- Please contact me before using my child's photo, name, interview, or student work in any school publication.

SIGNATURE OF PARENT GUARDIAN

I hereby verify that the above information is accurate to the best of my knowledge. I understand that if I deliberately misrepresent myself or my child, my child's seat may be revoked.

Parent/Guardian Name

Parent/Guardian Signature

Date



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Student Residency Enrollment Form

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers you give below will help the school determine what services you or your child may be able to receive.

Name of student (Last-First-Middle): _____

Sex: Male Female

Birth Date: __/__/__ Age: _____
Month/Day/Year

Social Security Number: _____
(or student identification number)

1. Is your current address a temporary living arrangement? _____ Yes _____ No
2. Is this temporary living arrangement due to loss of housing or economic hardship? _____ Yes _____ No

**If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO to the above questions, you may stop here.**

Where is the student currently living? (Check one box.)

- In a shelter
- With another family
- In a hotel/motel
- In a place not designed for ordinary sleeping arrangements such as a car, bus, train, or campsite
- Moving from place to place

Name of parent(s)/legal guardian(s): _____

Address _____ Zip Code _____

Phone Number _____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal Code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002 (3)(d).

Signature of Parent/Legal Guardian _____

Date _____

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Mc-Kinney-Vento Act Liaison Signature

Date



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MEDICAL INFORMATION AND RELEASE FORM

Student's Last Name _____ First Name _____ Date of Birth _____
 Grade/Class _____ OSIS# _____

MAIN CONTACT FOR TELEPHONE CALLS, EMAILS AND SCHOOL CORRESPONDENCE		
PARENT/GUARDIAN NAME	RELATION TO STUDENT	
HOME PHONE	CELL PHONE (circle preferred contact number)	WORK PHONE
HOME ADDRESS	APT	
CITY	STATE	ZIP
EMAIL		

Medical History (check all that apply)

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies (Food/Other) | <input type="checkbox"/> Mumps | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Physical Handicap | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Vision Impairment | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Convulsive Disorder | <input type="checkbox"/> Heart Condition | |

Doctor's Name _____ Doctor's Phone Number _____

Hospital Preference _____ Hospital Phone Number _____

Is your child taking any medication? Yes No *If yes, please list each medication the condition for which each is taken.*

Medication & Condition _____ Medication & Condition _____

Medication & Condition _____ Medication & Condition _____

Is your child presently under treatment for any physical problem? If yes, please explain.

Is your child allergic to any foods or other substances? Which ones? Please explain the procedure to follow if a reaction occurs.

Is there any physical condition that we should be aware of, and what precautions or procedures should be taken?

