



Congratulations! Your child is now eligible to fully register for admission to Heron Bay Academy for the 2011 - 2012 inaugural academic year.

Included with this coversheet you will find the registration packet containing **8** pages. Your child is currently pre-registered and has been awarded an available space via the October 2010 lottery, which means that we are saving a spot for your child for the 2011 – 2012 school year. However, space is limited and there is a waiting list for all grades. Therefore, your registration cannot be fully confirmed until this package is received and approved by Heron Bay Academy.

Once completed, please hand-deliver your registration package to the Heron Bay Lodge / Sales Center **by 5:00 pm** on Sunday **May 15, 2011**. The Lodge is located at 3080 Heron Bay Boulevard, Locust Grove, GA 30248.

Do Not mail your registration package, and **Do Not** leave it unattended at the Heron Bay Lodge.

Upon delivery, each package will be reviewed briefly while you wait and a receipt will be provided by Heron Bay Academy for each acceptable package.

ALL COMPLETED REGISTRATION PACKETS FOR PREVIOUSLY WAITLISTED STUDENTS MUST BE RETURNED BY THE NOV 6 DEADLINE, OR STUDENTS RISK THE LOSS OF THEIR LOTTERY ASSIGNED SPACE TO THE NEXT STUDENT IN LINE ON THE WAITING LIST.

The checklist below is for your use to make certain all documents are complete and in the order presented. Please fill out one set of the forms for each child and retain a copy of the completed forms for your records.

Forms included in this package that are required:

- Student Enrollment Package including Parent Guardian and Emergency Contact Information
- Volunteer Form
- Photograph/Videotape Permission form

Copies of other essential documents that are required:

- Birth Certificate
- Copy of the actual Social Security Card
- Proof of Residency (utility Bill, Tax Record, Lease)

Additional documents to be submitted ONLY if they apply to your child:

- IEP *if applicable*
- Application for Free and Reduced Lunch *if applicable*

Additional information that is recommended but not required until later:

- Child Health Assessment
- Certificate of Immunization
- Copy of Immunization Record
- Signed copy of the school's Code of Conduct *(form is not included in this package and will be provided later)*
- Signed Technology Use Policy and Permissions *(form is not included in this package and will be provided later)*
- Parent Request for Release of Student Records *(form is not included in this package and will be provided later)*

If you have any questions regarding this procedure or need assistance completing the forms please call: (404) 841-2305 ext. 1080.

FOR OFFICE USE ONLY

Process Date: ___/___/___ Student's First Day of School: ___/___/___ Student's Last Day of School: ___/___/___
Student Number _____ Enrollment Code: _____ Previous School ID#: _____ Previous School Student #: _____
Letter to Release Records sent: ___/___/___ School Records Received: ___/___/___ Sp. Ed. Records Received: ___/___/___
Code of Conduct Acknowledgement Returned: Yes Evidence of Enrollment Received: Yes

2011 – 2012 Enrollment Package

(Required by State)

All student information is protected by the Family Educational Rights to Privacy Act for the purpose of protecting student confidentiality

STUDENT BASIC INFORMATION

Student's Last Name:		
Student's First Name:		
Student's Date of Birth	⇒ Note: Must Provide Birth Certificate	
Student's Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Student's Age:
How will Student be transported to and from school?	<input type="checkbox"/> Parent Driver <input type="checkbox"/> Carpool <input type="checkbox"/> Bus <input type="checkbox"/> Walk <input type="checkbox"/> Day Care Van <input type="checkbox"/> Parent Walker (Gate) <input type="checkbox"/> City Bus <input type="checkbox"/> Other: (Explain):	
Student Bus # (if applicable):	Not applicable	
School District of Residence	district of residence where parent/guardian lives	
Student can be picked up by:	Name:	Relation to Child:
	Name:	Relation to Child:
	Name:	Relation to Child:
	Name:	Relation to Child:
August 2011 Grade Level	<input type="checkbox"/> Pre-K <input checked="" type="checkbox"/> K <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> 4th <input type="checkbox"/> 5th <input type="checkbox"/> 6th <input type="checkbox"/> 7 th <input type="checkbox"/> 8th	
Student's Social Security #		
Student Home Phone		
Home Email		
Student lives	<input type="checkbox"/> Both Biological Parents <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Both Parents Alternately: If both Parents alternately please indicate Custodial Parent: <input type="checkbox"/> Mother <input type="checkbox"/> Father	
Student Ethnicity:	<input type="checkbox"/> African American (Non-Hispanic) <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian / Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> White (Non-Hispanic)	
(if applicable)Country of Origin		Date Student Entered USA:
Native Language:	Is there a primary language other than English spoken in the home: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what language? _____	
	Does your child speak a language other than English? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what language? _____	
<i>The following question is intended to address the McKinney-Vento Act. Your response will help administrators determine residency documents necessary for enrollment of this student</i>		
Student lives	<input type="checkbox"/> in a house <input type="checkbox"/> in an apartment <input type="checkbox"/> in a shelter <input type="checkbox"/> in a motel, car, campsite <input type="checkbox"/> in a house w/more than one family <input type="checkbox"/> with friends or family other than parent/guardian	

STUDENT ADDRESS INFORMATION

I do or do not give my permission to include our child and family in the school directory

Street Address Where Student Lives	Street:
	City, State, Zip:
Mailing Address	<input type="checkbox"/> Same as Above or <input type="checkbox"/> Use the mailing address below:
	Street:
	City, State, Zip:

Do you need a second mailing to a non-custodial parent?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If yes – Provide Address: here ➡	Street:
		City, State, and Zip:

STUDENT EDUCATION INFORMATION

Name of Most Recent School			
Address of Former School			
Previous Grade	Has your child ever been retained in any grade? <input type="checkbox"/> Yes Grade: <input type="checkbox"/> No		
Student's Native Language	primary language spoken by the student:		
Was your child receiving Special Education Services?	<input type="checkbox"/> No	<input type="checkbox"/> Yes; do you have your child's special education records (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, attach copy</i>	
If your child receives Special Services complete this section ➡	When and where was testing performed? Date: ____/____/____ Location: _____		
	How many hours of Special Education/Services does your child receive per week? _____		
	Does the child have a 504 Plan? <input type="checkbox"/> Yes (Date Plan Developed: ____/____/____) <input type="checkbox"/> No		

STUDENT PARENT INFORMATION

Relationship	Name	Home Phone	Work Phone /Employer	Cell Phone #	E-Mail Address
Mother/Guardian					
Father/Guardian					
Step Parent					

STUDENT EMERGENCY CONTACT INFORMATION (in addition to parents)

Emergency Contact	Relationship	Emergency Phone #	Emergency Work Phone #	Emergency Cellular Phone #

STUDENT EMERGENCY CARE PERMISSION

Name of Child: _____ Age: _____ years _____ months

I hereby give permission to the staff of the school to secure emergency medical treatment for the above named child while under their supervision: Yes No - I do not give permission for the school to secure medical treatment

In the event emergency medical treatment is required, I give consent for my child to be transferred to the nearest medical facility and if necessary to be treated by a qualified physician. I understand that the school can **not** transport my child to the nearest medical facility. In the event that I can not be contacted and if my designated emergency contact is not available, I understand and agree that the school staff will telephone 911 for emergency medical assistance.

Signature: _____ Date Signed: ____/____/____

STUDENT HEALTH INFORMATION

Doctor's Name		Doctor's Phone	
Dentist's Name		Dentist's Phone	
Preferred Hospital		Date of Last Physical	
Health Insurance Policy Name and Number		Date of Last Tetanus Shot	
Medical Alert <i>Critical Health Issues (i.e. diabetes, hemophilia; severe allergies, etc.)</i>		Medical Concerns <i>Chronic Health Concerns (i.e. allergies; skin disorders)</i>	
List any special services your child has received in the last three (3) years		Other Information	

The information provided above is true and accurate: _____

Parent/Guardian Signature & Date

Volunteer Form

Volunteers may be involved in monitoring the playground, student drop-off and pick-up, crosswalk, and assisting with school events. In addition, parents are encouraged to contribute their time and talent to organizing extracurricular activities and community outreach projects. All parents/guardians are expected to volunteer 2 hours each month per parent/guardian in the household. Any family member – parent, sibling, grandparent, or family friend – may complete the hours for the family. Hours may be “banked” by serving several hours at once. A number of volunteer options are available both in the school and from home or work. Volunteer hours are logged and records are kept on file. Contact the school administrative team for volunteer suggestions. Also, refer to the school newsletter throughout the year for ways to be of service. The following is a partial list of ways to fulfill the volunteer commitment.

Please check as many boxes that fit your particular interests and availability.

During School Hours Volunteers May . . .

- Assist with small reading groups *
- Assist with small math groups *
- Share about your work or career
- Help teachers with classroom décor -- posters, boards, hallway art displays
- Help during reading groups, Paragon, and math
- Organize completed work into Friday Folders
- Photocopy homework or project packets
- Supervise or play with children during lunch *
- Work in the media center
- Clean school equipment or school grounds
- Type cumulative student records
- Answer office phone any day at mid day
- Volunteer with the student council
- Volunteer with the student choir
- Tutor students after school *
- Pick up and return books from the public library
- Playground supervisor*

After School Hours Or From Work Or Home Volunteers May . . .

- Assist teachers in correcting student work
- Assist with the school website
- Contact a paper or printing company and offer to collect outdated or unwanted paper products
- Host a talk at work to promote the school
- Organize a family drive to enlist in Target, Office Depot, or Wal-Mart Card Programs that donate to the school
- Share any fund raising experiences and ideas
- Provide general grounds maintenance
- Buy or send in Paragon supplies
- Organize Scholastic book orders for teachers
- Pick up and return books from the public library
- Shop for school supply donations – pencils, pens, paper towels, wet wipes, bleach wipes, Ziploc bags are needed throughout the year
- Request your office to donate art supplies
- Photocopy homework and project packets

* The types of volunteer service noted with an asterisk require successful completion of a criminal background check).

NOTE: Please write in any special interests you may have that you have: _____

NOTE: Please write in any other volunteer activity you feel will contribute to our school community: _____

I understand that Volunteering is expected.

All volunteers must complete a Character Questionnaire, and may be fingerprinted (if required for federal and state clearance). Volunteers receive and must follow all policies and procedures defined by the school. If activity occurs that is not in keeping with the school policies, the Chief Administrative Officer (CAO) reserves the right to relieve the volunteer of his or her responsibilities.

Parent/Guardian Signature

_____/_____/_____
Date

Photograph/Videotape Permission

Dear Parent:

From time to time school staff records student activities through the use of photography and/or videotape. Generally the resulting material is used internally to serve as a form of documentation of school/student activity and as a learning tool for both students and faculty. On occasion photographs and/or videotapes may be used for advertising purposes to promote enrollment at our school or as a backdrop to employment recruitment efforts.

In order for the school to produce materials for both internal and external uses we need your permission to use photo and/or video images of your child. Please put a check in the appropriate box and sign below to indicate your preference of permission for the following:

1. I **(do)** give permission for my child to be photographed/videotaped and the resulting photographs/videotape to be used and displayed within the school as well as, to be used for public display and/or published for the benefit of the school.
2. I **(do not)** give permission for my child to be photographed/videotaped and the photographs/videotape to be publicly displayed and/or published.

Please Note: There is no payment or any other form of compensation for use of your child's image if a photograph and/or video image of your child is used either internally or externally as explained in the examples above.

Please Print:

Student's Name: _____

Grade: _____ Teacher's Name: _____

Parent/Guardian Name: _____

Sign Below

Parent/Guardian Signature

_____/_____/_____
Date Signed

CHILD HEALTH ASSESSMENT

Parent/Guardian completes this section

Student Information:

<u>Last Name:</u>	<u>First Name:</u>	<u>Middle Name:</u>
<u>Child's Date of Birth:</u> ____ / ____ / ____	<u>Home Phone:</u>	<u>Parent/Guardian Name:</u>
<u>Home Address:</u>		
Check August 2011 Grade: K <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> SP ED <input type="checkbox"/>		
RACE/ETHNICITY: <input type="checkbox"/> African American (Non-Hispanic) <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian / Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Multiracial <input type="checkbox"/> White (Non-Hispanic)		

Consent:

I hereby give my consent as the parent/guardian of the above named child to release, discuss or otherwise inform the school of my child's health condition and any health concerns:

Parent/Guardian Signature: _____ Date Signed: ____ / ____ / ____

Physician completes this section

Heath History and Medical Information Pertinent to Routine Care:

Emergency Care: None Yes; describe:

Allergies to Food or Medicine: None Yes; describe:

Height	Weight	Head Circumference	Blood Pressure
____ IN/CM %of ILE ____	____ LB/KG %of ILE ____	____ IN/CM %of ILE ____	____ / ____

Physical Examination: **Date of Examination:** ____ / ____ / ____

<u>Physical Examination</u>	<u>Normal</u>	<u>Abnormal</u>	<u>Comments</u>
Head/Ears/Eyes/Nose/Throat			
Teeth			
Cardio/Respiratory			
Abdomen/GI			
Genitalia/Breasts			
Extremities/Joints/Back/Chest			
Skin / Lymph Nodes			
Neurological / Tone			
Developmental (E.G. DDST)			

CHILD HEALTH ASSESSMENT

Physician completes this section

Child's Name: _____

Screening Tests:

Screening Tests	Normal	Abnormal	Comments
LEAD			
ANEMIA (HGB/HCT)			
URINALYSIS (UA)			
HEARING			
VISION			
DATE OF DENTIST'S LAST EXAMINATION: ____/____/____			

Recommendations/Health Care Provider's Signature:

<p style="text-align: center;"><u>HEALTH PROBLEMS OR SPECIAL NEEDS</u></p> <p><input type="checkbox"/> <u>NO</u> Problems <input type="checkbox"/> <u>YES</u>, Describe:</p>	<p style="text-align: center;"><i>Recommended Treatment – Medication - Special Care</i> <i>(Attach Additional Sheets as Necessary)</i></p>
<p>Medical Care Provider:</p>	<p>NEXT APPOINTMENT: (MONTH/YEAR)</p> <p style="text-align: center;">____/____</p>
<p>Address:</p>	
<p>Phone:</p>	
<p>_____ Signature of Attending Physician or CRNP</p>	
<p style="text-align: right;">Date: ____/____/____</p>	
<p style="text-align: right;">MD DO CRNP</p>	

NOTE: Age appropriate health services and immunizations must follow the schedule recommended by The American Academy of Pediatrics.

CERTIFICATE OF IMMUNIZATION

<u>Last Name:</u>	<u>First Name:</u>	<u>Middle Name:</u>
<u>Child's Date of Birth:</u> ____/____/____	<u>Home Phone:</u>	<u>Parent/Guardian Name:</u>
<u>Home Address:</u>		<u>August 2011 Grade:</u>

<u>VACCINE</u> CIRCLE APPROPRIATE ITEM	ENTER MONTH, DAY, AND YEAR EACH IMMUNIZATION WAS GIVEN DOSES				
<i>Diphtheria and Tetanus</i> (DtaP, DTP, Td, or DT)	1) ____/____/____	2) ____/____/____	3) ____/____/____	4) ____/____/____	5) ____/____/____
<i>Polio (OPV or IPV)</i>	1) ____/____/____	2) ____/____/____	3) ____/____/____	4) ____/____/____	
Hepatitis B	1) ____/____/____	2) ____/____/____	3) ____/____/____		
Measles – Mumps – Rubella (MMR)	1) ____/____/____	2) ____/____/____	Or Measles Serology: Date: ____/____/____ titer: _____		
Varicella (Vaccine or Disease)	1) ____/____/____	2) ____/____/____	Rubella Serology: Date: ____/____/____ titer: _____		
Other	1) ____/____/____	2) ____/____/____	Mumps disease diagnosed by a physician: <input type="checkbox"/> Yes Date: ____/____/____		

Doses required by law for new school enterers (K or 1st Grade) are shaded in gray.

Age appropriate dose(s) of varicella vaccine or history of disease and 3 doses Hepatitis B vaccine required for entry into 7th grade.

To the best of my knowledge, this child has received the minimum required immunizations. Source: Written Verbal Both

Signed: _____ Date: ____/____/____
(PHYSICIAN, PUBLIC HEALTH OFFICIAL, SCHOOL NURSE, OR OTHER DESIGNEE)

Statement for Exemption to Immunization Law (If applicable)

MEDICAL EXEMPTION

The physical condition for the above named child is such that immunization would endanger life of health.

Signed: _____ Date: ____/____/____
Physician's Signature

RELIGIOUS EXEMPTION

Includes a strong moral or ethical conviction similar to a religious belief

The parent or guardian of the above named child adheres to a religious belief whose teachings are opposed to such immunizations. State your reasons for requesting religious exemption: _____

Signed: _____ Date: ____/____/____
Parent/Guardian Signature