Parent/Guardian Signature and Date

______________________________

# SunBridge Schools 2024-2025 Enrollment Form

2729 124th St Toledo OH, 43609

## Student Information

Last Name ______ First Name ______ Middle ______

Apartment Complex Name ______

Street Address ______ PO Box ______

City ______ State ______ Zip Code ______ Gender: ○ Male ○ Female

Grade for 24-25 School Year ______ Home Phone Number ______ Student Birth Date ______

Mother's Maiden Name ______ Student's Birth Place City ______

**Student Residency**

- ☐ Student lives in residence owned or rented by parents
- ☐ Student lives in a publicly operated shelter
- ☐ Student lives in a privately operated shelter
- ☐ Student lives with relatives or friends
- ☐ Student lives with friends or family other than parent/guardian
- ☐ Student lives with more than one family in a house or apartment
- ☐ Student lives in a hotel or motel

Does the living arrangement above result from a loss of housing or economic hardship? ☐Yes ☐No

Is the student of Hispanic/Latino heritage?
__ Yes ___ No

At least one race must be chosen below regardless if Yes or No was chosen above:
__ American Indian or Alaskan Native
__ Asian
__ Black or African American
__ White

Is the student a U.S. Citizen?
__ Yes __ No
If No:
Country of Origin__________________

## Parent/Guardian Information

Mother: ______ (Last Name) ______ (First Name) ______ (Address/City/Zip Code) __ Yes __ No Custody of Student?

______ Home Phone ______ Cell Phone ______ Email Address

Father: ______ (Last Name) ______ (First Name) ______ (Address/City/Zip Code) __ Yes __ No Custody of Student?

______ Home Phone ______ Cell Phone ______ Email Address

Step Parent: ______ (Last Name) ______ (First Name) ______ (Address/City/Zip Code) __ Yes __ No Custody of Student?

______ Home Phone ______ Cell Phone ______ Email Address

Guardian: ______ (Last Name) ______ (First Name) ______ (Address/City/Zip Code) __ Yes __ No Custody of Student?

______ Home Phone ______ Cell Phone ______ Email Address

SunBridge Schools 2024-2025 Enrollment Form

## School History (Last School Attended)

______________________________ ______________
Previous School Name 23-24 Grade

__________________________________________________________
Address/City/State/Zip

## Family Information

Name of school-age natural and step-brother and sisters now living at home

| Last Name | First Name | MI | DOB |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

__________________________________ ____________________
Emergency Contact Phone Number

__________________________________ ____________________
Family Dentist Phone Number

__________________________________ ____________________
Family Doctor Phone Number

________________________________________________________
Medical History, allergies, medications, physical Impairments or other conditions

________________________________________________________
Preferred Hospital Name

Do you give consent for the administration of emergency treatment, if emergency contact person cannot be reached? ___ Yes ____ No

## Parent Employment

Mother: ____________________ ________________________
Employer Name Employer Phone Number

________________________________________________________
Employer Address/City/State/Zip

Father: ____________________ ________________________
Employer Name Employer Phone Number

________________________________________________________

Step Parent: __________________ ________________________
Employer Name Employer Phone Number

________________________________________________________
Employer Address/City/State/Zip

Guardian: ____________________ ________________________
Employer Name Employer Phone Number

________________________________________________________
Employer Address/City/State/Zip

## Pick Up Permission

Names of any people outside of parent/guardian who can pick your student up from school

| First Name | Last Name | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Special Services

Is your child receiving any special services?

IEP ___ Yes ___ No 504 Plan ___ Yes ___ No Other ___Yes ___ No

*If Yes is this IEP for*

___*Academics* ___ *Behavior* Please provide copies of any ETR, IEP, Service Plan, 504, etc.

EMERGENCY MEDICAL AUTHORIZATION FORM 24-25

Student Name: ____________________________________________________________________ Grade: _________________
Address: __________________________________________________________ Phone Number: ________________________

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

**Residential Parent/Guardian**

Mother's Name: ____________________________________________________ Daytime Phone: ______________________________

Father's Name: _____________________________________________________ Daytime Phone: ______________________________

Other: ______________________________ (Relationship) ____________________ Daytime Phone: ______________________________

**Relative/Child Care Provider**

Name: ____________________________________________________________ Daytime Phone: ______________________________
Address: __________________________________________________________ Daytime Phone: ______________________________

Name: ____________________________________________________________ Daytime Phone: ______________________________
Address: __________________________________________________________ Daytime Phone: ______________________________

**Medical Care Providers (*MUST BE COMPLETED)***

Doctor: ___________________________________________________________ Phone Number: ______________________________

Dentist: __________________________________________________________ Phone Number: ______________________________

Medical Specialist: _________________________________________________ Phone Number: ______________________________

Preferred Hospital: _________________________ Phone Number: ____________________ ER Phone Number: _____________________

**Please Complete *Either* Part 1 or Part 2 Below:**

***Part 1: CONSENT TO TREAT***

*I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS AND LOCAL HOSPITAL TO BE CALLED 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 THE ABOVE NAMED DOCTOR, OR IN THE EVENT THE DESIGNATED PREFERRED PRACTITIONER IS NOT AVAILABLE, BY OTHER LICENSED PHYSICIAN OR DENTIST; AND (2) THE TRANSFER OF THE CHILD TO ANY HOSPITAL REASONABLY ACCESSIBLE. THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS OR DENTISTS, CONCURRING IN THE NECESSITY FOR SUCH SURGERY, ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY.* ***FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES (all allergies including food, medication, environment), MEDICATIONS BEING TAKEN, AND ANY OTHER PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED INCLUDE:***

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

Parent/Guardian Signature: _____________________________________________ Date: ________________________________
Address: __________________________________________________________ Daytime Phone: ______________________________

***Part 2: 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 THE SCHOOL AUTHORITIES TO TAKE THE FOLLOWING ACTION:*

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

Parent/Guardian Signature: _____________________________________________ Date: ________________________________
Address: __________________________________________________________ Daytime Phone: ______________________________

# OVER-THE-COUNTER MEDICATIONS (OTC) PARENT PERMISSION FORM 24-25

**The school nurse for SunBridge Schools is authorized to administer the following over-the-counter medications during the school day:**

- THROAT LOZENGE—for irritated/sore throat
- IBUPROFEN (Advil/ Motrin)—for headaches, body aches or menstrual cramps
- ACETAMINOPHEN (Tylenol)—for headaches, body aches, or menstrual cramps
- TUMS –for upset stomach or indigestion
- COUGH DROPS—irritated cough/irritated throat
- Benadryl – for rash, itching, watery eyes/nose/throat, running nose and sneezing
- Claritin – for rash, itching, watery eyes/nose/throat, running nose and sneezing

**To assure safe administration of OTC medications to students during the school day, the school nurse will**:

- Assess the student's condition, current medication profile, history of allergies and evaluate the need for medication.
- Review the signed parent permission form, which is valid for one school year.
- Call the parent/guardian to confirm, when necessary, the time of the last dose given.
- Administer the correct dosage according to child's age and weight.
- Document the medication administration in the health office visit log.
- Contact parent/guardians who have requested notification following OTC medication administration during the school day.
- When needed parents will bring a supply of the OTC medication in the original package to be kept in the nurse's office and are responsible to keep an appropriate quantity at school.

---

## I give my consent to the school nurse to administer the following medications as needed during the school day.

**Please cross out any of the following that you do not allow:**

- IBUPROFEN
- ACETAMINOPHEN
- TUMS
- COUGH DROPS/THROAT LOZENGE
- Benadryl
- Claritin

Student's name: ________________________________ DOB: ____________________

Parents' Signature: ______________________________ Date: ____________________

Parent's Phone Numbers: (cell)________________ (work)_______________

Please notify me when OTC medication is administered to my child during the school day. Yes_____No______

Email__________________________________Phone_________________

School Health Examination Record – Health & Immunization History

**PART I - TO BE COMPLETED BY PARENT / GUARDIAN- ALL STUDENTS**

Child's Name ______________________________________________

(Print) Last First Middle

## A. ALLERGIES – PLEASE LIST AND DESCRIBE **ALLERGIES** OR REACTIONS TO:

Medicines/Drugs: ______________________________

Foods/Plants/Animals/Other: ______________________________

Recommended treatment is allergy is severe: ______________________________

## B. INJURIES AND ILLNESSES – PLEASE LIST ANY SEVERE INJURIES OR ILLNESSES:

| Injury / Illness | Age of Child | Check if hospitalized |
|---|---|---|
| | | |
| | | |
| | | |

## C. ADDITIONAL INFORMATION:

What medications are given daily? ______________________________

______________________________

What medications are given frequently, not daily? ______________________________

______________________________

This child is usually: ☐ very active ☐ normally active ☐ rather inactive

Does any relative or anyone in the home have tuberculosis, diabetes or other serious illness? ____________

Is there anything about your child that the school/teacher needs to know to understand him/her better? ________

______________________________

## D. OTHER PERTINENT MEDICAL INFORMATION:

______________________________

______________________________

______________________________

______________________________

## E. SIGNATURE OF PARENT/GUARDIAN:

______________________________ ______________

*Signature of Parent/Guardian* *Date Signed*

School Health Examination Record – Health & Immunization History

**PART II – TO BE COMPLETED BY PHYSICIAN PRIOR TO SCHOOL ADMISSION- NEW STUDENTS ONLY**

Print Student's Last Name ____ First ____ M.I. ____ Date of Birth ____

**F. IMMUNIZATION RECORD:** Minimum requirements are listed for each vaccine. Those marked with an (*) are required by the Ohio Department of Health; all others are recommended by the Centers for Disease Control and Prevention.

| RECOMMENDED IMMUNIZATION (ENTER MONTH, DAY AND YEAR) | | | | | |
|---|---|---|---|---|---|
| **VACCINES** | **DOSE 1** | **DOSE 2** | **DOSE 3** | **DOSE 4** | **DOSE 5** |
| Diphtheria (DTaP), Tetanus (DT/Tdap/Td), Pertussis* | | | | | |
| DTap (7th – 9th grade only) * | | | | | |
| Hepatitis B (Hep B) * | | | | | |
| Measles, Mumps, Rubella (MMR) * | | | | | |
| Polio (IPV or OPV) * | | | | | |
| Varicella (Chicken Pox) * [2 doses K-2; 1 dose 3 – 6] | | | | | |
| Influenza | | | | | |
| Pneumococcal Conjugate (PCV) | | | | | |
| Meningococcal | | | | | |
| Hepatitis A | | | | | |
| Haemophilus Influenza – type b (HIB, preschool only) | | | | | |
| Human Papillomavirus (Gardasil) | | | | | |

**Recommended Assessments/ Screenings:**

Vision: ❍ Yes ❍ No Date: ______________ Hearing: ❍ Yes ❍ No Date: ______________

Dental: ❍ Yes ❍ No Date: ______________ Lead: ❍ Yes ❍ No Date: ______________

BMI: ❍ Yes ❍ No Date: ______________ Other: ❍ Yes ❍ No Date: ______________

*I have examined this child and found that he/she is in suitable condition for participation in school.*
*The child has had the age appropriate immunizations as recommended by the Ohio Department of Health.*
*My office has entered the child's immunization record as noted above or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons:*

List any limitations or health conditions for this child (including allergies, daily medication and dietary restrictions):

**G. SIGNATURE OF PHYSICIAN/PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE:**

______________________________ Date of Examination ______________

Printed Name ______________________________

Office Address ______________________________

City/State/Zip ______________________________ Office Phone: ______________

# HOUSEHOLD INFORMATION SURVEY

**SunBridge Schools is participating in the Community Eligibility Option (CEO) provision under the National School Lunch Program. Under CEO, all children in the school will receive a breakfast/lunch at no charge regardless of completion of this form. However, to determine eligibility for various additional state and federal program benefits that your child(ren)'s school may qualify for, please complete, sign and return this application to your student's building if your income falls within or below the guidelines listed in the following chart.**

## 2024 Federal Poverty Guidelines

INCOME ELIGIBILITY GUIDELINES

Effective from July 1, 2023 to June 30, 2024

| HOUSEHOLD SIZE | FEDERAL POVERTY GUIDELINES | REDUCED PRICE MEALS - 185 % | | | | | FREE MEALS - 130 % | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ANNUAL | ANNUAL | MONTHLY | TWICE PER MONTH | EVERY TWO WEEKS | WEEKLY | ANNUAL | MONTHLY | TWICE PER MONTH | EVERY TWO WEEKS | WEEKLY |
| **48 CONTIGUOUS STATES, DISTRICT OF COLUMBIA, GUAM, AND TERRITORIES** | | | | | | | | | | | |
| 1 ........ | 14,580 | 26,973 | 2,248 | 1,124 | 1,038 | 519 | 18,954 | 1,580 | 790 | 729 | 365 |
| 2 ........ | 19,720 | 36,482 | 3,041 | 1,521 | 1,404 | 702 | 25,636 | 2,137 | 1,069 | 986 | 493 |
| 3 ........ | 24,860 | 45,991 | 3,833 | 1,917 | 1,769 | 885 | 32,318 | 2,694 | 1,347 | 1,243 | 622 |
| 4 ........ | 30,000 | 55,500 | 4,625 | 2,313 | 2,135 | 1,068 | 39,000 | 3,250 | 1,625 | 1,500 | 750 |
| 5 ........ | 35,140 | 65,009 | 5,418 | 2,709 | 2,501 | 1,251 | 45,682 | 3,807 | 1,904 | 1,757 | 879 |
| 6 ........ | 40,280 | 74,518 | 6,210 | 3,105 | 2,867 | 1,434 | 52,364 | 4,364 | 2,182 | 2,014 | 1,007 |
| 7 ........ | 45,420 | 84,027 | 7,003 | 3,502 | 3,232 | 1,616 | 59,046 | 4,921 | 2,461 | 2,271 | 1,136 |
| 8 ........ | 50,560 | 93,536 | 7,795 | 3,898 | 3,598 | 1,799 | 65,728 | 5,478 | 2,739 | 2,528 | 1,264 |
| For each add'l family member, add | 5,140 | 9,509 | 793 | 397 | 366 | 183 | 6,682 | 557 | 279 | 257 | 129 |
| **ALASKA** | | | | | | | | | | | |
| 1 ........ | 18,210 | 33,689 | 2,808 | 1,404 | 1,296 | 648 | 23,673 | 1,973 | 987 | 911 | 456 |
| 2 ........ | 24,640 | 45,584 | 3,799 | 1,900 | 1,754 | 877 | 32,032 | 2,670 | 1,335 | 1,232 | 616 |
| 3 ........ | 31,070 | 57,480 | 4,790 | 2,395 | 2,211 | 1,106 | 40,391 | 3,366 | 1,683 | 1,554 | 777 |
| 4 ........ | 37,500 | 69,375 | 5,782 | 2,891 | 2,669 | 1,335 | 48,750 | 4,063 | 2,032 | 1,875 | 938 |
| 5 ........ | 43,930 | 81,271 | 6,773 | 3,387 | 3,126 | 1,563 | 57,109 | 4,760 | 2,380 | 2,197 | 1,099 |
| 6 ........ | 50,360 | 93,166 | 7,764 | 3,882 | 3,584 | 1,792 | 65,468 | 5,456 | 2,728 | 2,518 | 1,259 |
| 7 ........ | 56,790 | 105,062 | 8,756 | 4,378 | 4,041 | 2,021 | 73,827 | 6,153 | 3,077 | 2,840 | 1,420 |
| 8 ........ | 63,220 | 116,957 | 9,747 | 4,874 | 4,499 | 2,250 | 82,186 | 6,849 | 3,425 | 3,161 | 1,581 |
| For each add'l family member, add | 6,430 | 11,896 | 992 | 496 | 458 | 229 | 8,359 | 697 | 349 | 322 | 161 |
| **HAWAII** | | | | | | | | | | | |
| 1 ........ | 16,770 | 31,025 | 2,586 | 1,293 | 1,194 | 597 | 21,801 | 1,817 | 909 | 839 | 420 |
| 2 ........ | 22,680 | 41,958 | 3,497 | 1,749 | 1,614 | 807 | 29,484 | 2,457 | 1,229 | 1,134 | 567 |
| 3 ........ | 28,590 | 52,892 | 4,408 | 2,204 | 2,035 | 1,018 | 37,167 | 3,098 | 1,549 | 1,430 | 715 |
| 4 ........ | 34,500 | 63,825 | 5,319 | 2,660 | 2,455 | 1,228 | 44,850 | 3,738 | 1,869 | 1,725 | 863 |
| 5 ........ | 40,410 | 74,759 | 6,230 | 3,115 | 2,876 | 1,438 | 52,533 | 4,378 | 2,189 | 2,021 | 1,011 |
| 6 ........ | 46,320 | 85,692 | 7,141 | 3,571 | 3,296 | 1,648 | 60,216 | 5,018 | 2,509 | 2,316 | 1,158 |
| 7 ........ | 52,230 | 96,626 | 8,053 | 4,027 | 3,717 | 1,859 | 67,899 | 5,659 | 2,830 | 2,612 | 1,306 |
| 8 ........ | 58,140 | 107,559 | 8,964 | 4,482 | 4,137 | 2,069 | 75,582 | 6,299 | 3,150 | 2,907 | 1,454 |
| For each add'l family member, add | 5,910 | 10,934 | 912 | 456 | 421 | 211 | 7,683 | 641 | 321 | 296 | 148 |

**If any member of your household receives Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) or Ohio Works First (OWF) benefits, provide the name and 10-digit case number for the person who receives the benefits then proceed to Section 4. If no one receives these benefits, start with Section 1.**

Name: Case Number:

## Child's Name: ___________________________

**INSTRUCTIONS:** Complete survey and return to your child's school

**These selections must be completed by the Head of Household or Designee**

1. **SIZE OF FAMILY** - Indicate the total number of individuals living in your household, including all adults and children:_______
2. **STUDENT INFORMATION** - Complete for each student Pre-K through 12th grade

| Last Name | First Name | Birth Date MM-DD-YY | School | Identify H if Homeless M if Migrant R if Runaway F if Foster |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |

If you need additional lines, attach a second sheet to this survey or attach a copy of this survey clearly marked as Page 2

3. **TOTAL MONTHLY HOUSEHOLD INCOME** – Report Income for all members of household excluding Foster Children. If you have reported a case number above, you do not need to fill in this section. Simply sign and date this form.

| Type of Income | Income | Circle if No Income |
|---|---|---|
| 1. Gross Monthly Earnings: Wages, Salary, Commissions | $ | None |
| 2. Monthly Welfare Payments, Child Support, Alimony | $ | None |
| 3. Monthly Payments from Pensions, Retirement, Social Security | $ | None |
| 4. Monthly Dividends or Interest on Savings | $ | None |
| 5. Monthly Worker's Compensation, Unemployment, Strike Benefit | $ | None |
| 6. Other Monthly Income (SSI, VA, Disability, Farm, other) | $ | None |
| **Total Monthly Household Income** (Add lines 1-6) | $ | |

4. **SIGNATURE** - If Income Section is completed, the adult signing the form must also list the last four (4) digits of his or her Social Security Number or check the "I do not have a Social Security Number" box below.

I certify (promise) that all information on this application is true and that all income is reported. I understand the school will be eligible for certain federal and/or state funds based on the information I give. I understand that the school officials may verify (check) the information. I understand that if I purposely give false information, my child may lose benefits and I may be prosecuted.

Sign Here: X_______________________________________________ Print Name:_____________________________________

Date____________________

Last Four (4) Digits of Adult Social Security Number: XXX-XX-___________ ☐ I do not have a Social Security Number

| Address | City | Zip Code |
|---|---|---|
| | | |

| Home Phone | Work Phone | Email Address |
|---|---|---|
| | | By providing your email address, you may be contact via email by the district |

**For Office Use Only:**

Circle One

QUALIFIES DOES NOT QUALIFY

## MEDIA RELEASE PERMISSION

From time to time we take pictures and video record students during school activities. We would like your permission to use these pictures/videos on our website, in our newsletters, or on our bulletin boards. We will never provide any specific information regarding your child. We also will never sell these pictures or videos; we will use them solely for SunBridge Schools Purposes.

## MOVIE PERMISSION

At times throughout the school year, we will be **using movies** in class to supplement lessons or as a reward for good behavior. These movies have the possibility of having a rating of G or PG (parental guidance). District regulations require teachers to have parental permission to show any movies rated over G in class. By signing this permission slip, you are allowing your child to watch a G or PG rated movie in class.

## COMPUTER NETWORK PERMISSION SLIP

I understand that my child will have access to and will be using the SunBridge Schools Network, e-mail, and other school-supported media. I also understand that the use of the SunBridge Schools Computer Network is used for state mandated testing. ******Please note: This signed permission slip must be on file at school in order for your child to use the network for the 2024-2025 school year.***

_______________________________________________

Child's Name (Please Print)

_______________________________________________

Parent/Guardian's Name (Please Print)

_______________________________________________

Parent/Guardian's Signature Date

**YES**, I give permission for my student for the following items:

☐ Pictures ☐ Videos ☐ Movies ☐ Computer Network

**NO**, I do not give permission for my student for the following items:

☐ Pictures ☐ Videos ☐ Movies ☐ Computer Network

*(I allow Computer Network use for testing purposes only).*

**2024-2025 FIELD TRIP PERMISSION SLIP/ALLERGY INFORMATION**

*I understand that participation on school field trips are a privilege and not a guarantee. Student behavior may affect a child's ability to attend field trips. This form will be kept on file and used as an agreement for all field trips in the 24-25 school year. If your child is not invited to participate on a future field trip due to behavior issues or safety concerns, the classroom teacher will notify you.*

Student Name: ________________________________ Date of Birth: _______________Current Grade:_

*Parent/Guardian Contact Information:*

Name: _______________________________________ Phone #:________________________________

*Emergency Contact Information:*

Name: _______________________________________ Phone #:________________________________

**Medical Information:**

__ No Known Allergies __ Food Allergy, Describe: _________________________________________

__ Medication Allergy, Describe: ___________________________________________________________

Health Conditions which may cause physical restrictions: ______ None

__ Asthma __ Fainting/Dizziness __ Hearing Impairment __ Seizure Disorders

__ Heart Condition __ Significant Visual Impairment __ Other:_________________________________

Does your child carry emergency medication? Yes or No If yes, what is the medication?

____________________________________________________________________________________________________

*The above information is accurate to the best of my knowledge and I will update SunBridge Staff if any of the information changes.*

Parent/Guardian's Signature: _______________________________________ Date: ________________

Ohio | Department of Education

## Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

| **Student Name:** *(First Name and Last Name)* | **Student Date of Birth:** *(mm/dd/yyyy)* |
|---|---|
| **Communication Preferences**<br>Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand. | 1. In what language(s) would your family prefer to communicate with the school?<br>________________________________________ |
| **Language Background**<br>Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed. | 2. What language did your child learn first?<br>________________________________________<br>3. What language does your child use the most at home?<br>________________________________________<br>4. What languages are used in your home?<br>________________________________________ |
| **Prior Education**<br>Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child. | 5. In what country was your child born? ____________________<br>6. Has your child ever received formal education outside of the United States?<br>☐ Yes ☐ No<br>If yes, how many years/months? ________________<br>If yes, what was the language of instruction? ________________<br>7. Has your child attended school in the United States? ☐ Yes ☐ No<br>If yes, when did your child first attend a school in the United States?<br>______ / ______ / _______<br>Month Day Year |
| **Additional Information**<br>Please share additional information to help us understand your child's language experiences and educational background. | |
| Parent/Guardian First Name: ____________________<br>Parent/Guardian Signature: ____________________ | Parent/Guardian Last Name: ____________________<br>Today's Date: *(mm/dd/yyyy)* ____________________ |

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: https://www2.ed.gov/about/offices/list/ocr/ellresources.html

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# Transportation Request Form

**Student's Name:** _________________________________ Date of Birth: _____________ Date: ____________

Address: ____________________________________________________________________________

Contact Phone: ________________________________________________________________________

**Morning Transportation Address if not the same as above:**

______________________________________________________________________________

______________________________________________________________________________

**Afternoon Transportation Address if not the same as above:**

______________________________________________________________________________

______________________________________________________________________________

Grade: ___________ Previous Bus (if on one): ____________________________________

**Emergency Contacts:**

Name: _______________________________________________________________________________

Phone: _______________________________________________________________________________

Name: _______________________________________________________________________________

Phone: _______________________________________________________________________________

Medical Concerns: ______________________________________________________________________

Notes: ______________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

_______ (Initials) I have read & reviewed all bus safety procedures with my child and understand that my child may be suspended from the bus if they do not follow safety rules & procedures that are in place.

________(Initials) I understand that, if my child is suspended from the bus, it is my responsibility to arrange transportation and ensure that (s)he is in school on time.

________ (Initials) I give permission for my child to walk home from the bus stop without an adult present. This includes permission to walk home form the bus stop & waiting at the bus stop unsupervised.

________ (Initials) I understand that SunBridge Schools are not responsible for my child while (s)he is not in their care.

Parent Guardian Signature: ____________________________________ Date: _______________________

**Transportation Use Only**

Date Received: _________ Start Date: __________ Bus Number: ________________

# Transportation Request Form

The bus driver/aide is responsible for the safety of all students on the bus. Additionally, the Transportation Director, Mrs. Vikki Colbert, is available when a situation is beyond the control of the bus driver/aide. Students who have the opportunity to ride school buses may do so as long as they display behavior that is reasonable and safe. Some bus rides may be 2 hours long because of traffic and/or trains.

## Bus Behavior Rules

(According to OAC 3301-83-08)

1. Students are to remain seated at all times while the bus is running. No jumping seats, standing up, or walking the aisles. Bus aisles are to be kept clear at all times.
2. Disruptive and aggressive behavior will not be permitted. Students should keep their hands to themselves at all times.
3. Students are not allowed to touch any of the red exit handles (except in case of emergency) on windows or stick their arms, hands or head out of windows.
4. Yelling, screaming, and inappropriate language is not permitted on the bus. All students must be silent at railroad crossings.
5. Students are to be at their bus stop 5 minutes before the scheduled pick up time. Students are to remain a safe distance (6 feet) from the bus until the bus has stopped. Playing in the road is not acceptable.
6. Students must refrain from eating and drinking on the bus, except for documented medical reasons.

A copy of these rules is available in the student handbook or in the SunBridge Schools Transportation Office.