21st Century Public Academy

New Student Registration Packet

21st Century Public Academy
4300 Cutler Ave. NE; Albuquerque, NM 87110
Phone: (505)254-0280 Fax: (505)254-8507

21st Century Public Academy
"Building Knowledge for the Future"
4300 Cutler Ave NE ● Albuquerque, NM 87110
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AUTHORITY TO TRANSFER EDUCATIONAL RECORDS

I, _____, the parent or legal guardian of

_____
Last First Middle Grade

_____ _____
Date of Birth Student ID #

hereby authorize the transfer of all of the above student's educational records from:

_____ _____
Elementary School District Middle School

to 21st Century Public Academy.

My child intends to enroll or is enrolled at this school. Please send his/her cumulative records, health records, grades to date of leaving, and Special Education working folder where applicable.

Special Education Folder on file (IEP)

No Yes

_____
21st Century Public Academy

_____
Date

1st Request_____
2nd Request_____
3rd Request_____

The Family Education Rights and Privacy Act of 1974 as amended in 1976 allows school records to be forwarded without written consent to the school in which a student seeks or intends to enroll. (Federal Register, June 17, 1976, Vol. 41, #118-24673).

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Health/Emergency Information 2018-2019

Name	Birth Date	Grade	Teacher
Student Address		Home Phone	
Father's Name		Cell Phone	Work Phone
Mother's Name		Cell Phone	Work Phone
Lives With		Home Phone	Work Phone

ALTERNATE EMERGENCY CONTACTS

If parent/guardian cannot be reached, the school is authorized to process as indicated below:

1.	Phone
2.	Phone

INSURANCE INFORMATION

Health Insurance Company (if covered)	Medicaid # (If covered)

In case of an emergency involving my child and I cannot be reached, I hereby give my consent to transport my child to the following medical care providers and hospital, and authorize these providers and hospital to give any reasonable and customary medical and heal care deemed necessary:

Doctor	Phone
Dentist	Phone
Nurse Practitioner/Physician Assistant	Phone
Hospital	Phone

If, for any reason, the above listed medical care providers or hospital cannot be reached, I authorize appropriate transport and medical care of my child to any appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless on other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care.

Signature of Parent/Guardian	Date

PLEASE COMPLETE BOTH SIDES OF FORM

Condition	Year/Age Condition Occurred	Condition	Year/Age Condition Occurred
Asthma		Meningitis	
Diabetes		Migraine Headaches	
Ear/Hearing Problems	Type:	Muscular Weakness or Paralysis	
Emotional Problems	Type:	Bleeding Disorders	Type:
Seizures		High Blood Pressure	
Heart Problems		Infectious Diseases	Type:
Hepatitis	Type:	Tetanus Shot	Date:

Other:		
Allergies:		
Reactions to Medicine or Injections?		
Hospitalized for Serious Illness, Surgery, or Accidents? (If yes, explain)		
Long Term Medications?		
Use of Contact Lenses? (Circle One)	Yes	No
Have you ever been informed of the need to be on antibiotic therapy prior to dental treatment? If Yes, identify required therapy:	Yes	No
Please add any problems not listed:		

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Registration Form 2018-2019

Last Name	First Name	Middle Initial	Gender

Street or Rural Address, with Zip Code	Home Telephone

Student's Birthplace (Country Only)	If not USA, years in country	Date of Birth

STUDENT ETHNICITY: Enter the number of the student's ethnicity from the list below. A second ethnicity may be entered if appropriate. 1 = Anglo 4 = American Indian or Alaska Native 2 = African American/Black 5 = Asian or Pacific Islander 3 = Hispanic 6 = Other (write ethnicity in box)	Ethnicity	Second Ethnicity

PRESCHOOL CATEGORY: What type of preschool did the student attend? Enter the letter from the list below. A = Did not attend preschool C = Public preschool B = Private preschool D = Headstart program	Preschool Category

School Last Attended	Address, City, State, Zip (if not an APS school)	Date Last Attended

Has your family moved in the past 36 months to another city or state to pick crops, weed fields, work on ranches or work in canneries? (Yes/No)	

	Last Name	First Name	M.I	Living with this person	Legal guardian	Home Phone	Cell Phone
MOTHER							
	Street Address			Zip Code	Employer		
	Email address:				Work Phone:		
FATHER	Last Name	First Name	M.I.	Living with this person	Legal guardian	Home Phone	Cell Phone
	Street Address			Zip Code	Employer		
	Email address:				Work Phone:		
If other than mother or father, person with whom student lives	Last Name	First Name	M.I.		Legal guardian	Home Phone	Work Phone
	Street Address			Zip Code	Employer		

Emergency Contact	Phone #	Family Physician	Phone #

Is student covered by health insurance?	Insurance Company	Is student covered by Medicaid?	Medicaid number

PLEASE COMPLETE BOTH SIDES OF FORM

Name of each school age child			School	Grade	Emergency Phone #	Date of Birth		
Last Name	First Name	M.I				Month	Day	Year

21st Century Public Academy Home Language Survey

Our school needs to know the language(s) spoken and heard at home by each child. This information is needed in order for us to provide the best instruction possible for all students.

1. Which language(s) has your child learned to speak? _____

   _____

2. What language(s) does your child use most often at home?_____

   _____

3. What languages are commonly used in speaking with your child?_____

   _____

4. What language do you prefer to use when contacted by the school?_____

   _____

_____ _____

Parent Signature Date

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OUT OF SCHOOL INSTRUCTION (OSI) POLICY

We will be going on many OSI trips throughout the school year. At times, these trips may be planned for the entire team or broken up into smaller groups of students. Our OSI trips fall into three general categories: Educational/Instructional, Community Service, and Reward/Incentive.

As a team, we will draft an "OSI Behavior Contract". This contract will establish the expectations and guidelines that must be met for any student to participate in a team OSI trip. At least three days prior to any OSI trip we will go over with students any special requirements for a particular OSI trip. For example: their signed permission slip, writing materials they may need, appropriate dress code, a student's sack lunch, etc.

On the day of an OSI trip, any student who arrives at school unprepared or without the necessary and required items will not be allowed to go on that day's OSI trip.

During an OSI trip, any student whose behavior or actions violates our team's "OSI Behavior Contract" may be immediately brought directly back to school by the quickest transportation available. For example, we may call the school to send someone to transport the student back to school, or a teacher may personally escort the student back to campus (see Emergency Transportation Authorization below).

Whenever a student violates or breaks his or her "OSI Behavior Contract", then that student will not participate in the next up-coming OSI trip, regardless of what type of trip is next.

For any student who is staying behind at our campus, we will provide alternative lesson plans that will need to be completed as regular school assignments. **If a student has been informed that, due to his or her behavior, they will not be participating on a given OSI trip, we still expect that student to come to school.** In this example, if that student is absent on the day of the OSI trip, they will not go to the next OSI trip.

EMERGENCY TRANSPORTATION AUTHORIZATION

When on an Out of School Instruction (OSI) trip if it becomes necessary to transport my child due to emergency or behavioral issue in a private vehicle, then

I, _____, parent of _____, give my permission.

OUT OF SCHOOL INSTRUCTION (OSI) MEDICAL FORM

RE: MEDICAL SERVICES FOR ILL OR INJURED STUDENTS OR STUDENTS WHO ROUTINELY MUST TAKE MEDICATIONS OR WHO HAVE MEDICAL CONCERNS THAT MAY REQUIRE TREATMENT WHILE PARTICIPATING IN SCHOOL SPONSORED ACTIVITIES OR OSI TRIPS.

Dear parent/guardian of _____
Name of student

21st Century Public Academy wishes to avoid difficulties in obtaining medical services for students who may become ill or injured during school sponsored activities. As the parent/guardian of a student participating in a school sponsored activity, it is necessary that you consent, in advance, to hospitalization, medical attention, and surgery for your child in a case an emergency occurs. You must provide direction if no consent is given.

In the event of illness or injury, a reasonable effort will be made to contact you obtain consent in advance of medical services being given. If we are unable to contact you, the activity sponsor will consent to such services for your child by acting in your behalf based on written advance authorization. That authorization is in the consent form below.

Selection of a doctor or hospital will be made on the basis of family preference, if known. If family preference is unknown, the student will be taken to the closest hospital or one consistent with the existing circumstances.

AUTHORIZATION FOR MEDICAL SERVICES

I, the parent/guardian of _____ have read the above and hereby designate the sponsor of the OSI or activity trip to act in my behalf in the event of a medical emergency. He/she may authorize such hospitalization, medical attention, and surgery as may be required in an emergency because of illness or injuries sustained by my child while participating in school sponsored activities. I hereby assume financial responsibility for hospitalization, medical attention, and surgery provided.

1. List medical concerns (including allergies) which sponsor and chaperones need to be aware of.

2. List prescription medications, for which an authorization form to be taken at school has been filled out, that need to be taken by or administered to student while on a field trip or participating in extracurricular or cocurricular activities

3. List prescription medications, for which an authorization form to be taken at school has been filled out, that need to be taken by or administered to student in an emergency

LIMITED OR NO MEDICAL SERVICES AUTHORIZED

IF PARTICIPATION IN OSI OR ACTIVITY TRIP IS PERMITTED BUT MEDICAL SERVICES ARE NOT AUHTORIZD, PLEASE ATTACH A WRITTEN STATEMENT INCLUDING PROCEDURES TO BE FOLLOWED IF YOUR CHILD IS INJURED OR ILL DURING THE TRIP.

EMERGENCY CONTACT INFORMATION – PLEASE PRINT CLEARLY

_____
STUDENT HOME ADDRESS

_____ _____
PARENT HOME PHONE NUMBER PARENT WORK PHONE NUMBER

_____
NAME OF OTHER EMERGENCY CONTACT, RELATIONSHIP, AND PHONE NUMBER

_____
MEDICATION(S) STUDENT IS TAKING, KNOWN ALLERGIES TO MEDICATION OR FOODS

_____ _____
PARENT SIGNATURE DATE

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RULES FOR ACCEPTABLE INTERNET USE PERMISSION FORM

As a user of the Internet (on campus or off campus), I have read and understand the 21st Century Public Academy Rules for Acceptable Internet Use. I hereby agree to comply with said rules – communicating over the network in an appropriate manner (this means no accessing of objectionable content, no chat rooms and no unapproved games) while honoring all relevant laws and restrictions. I understand the consequences for breaking the rules.

I also understand that I will be held responsible for any repairs and/or labor costs that occur as a result of my misuse or damage to any computer, computer data, or inappropriate use of the Internet made available by 21st Century Public Academy.

Student Signature: _____ Date: _____

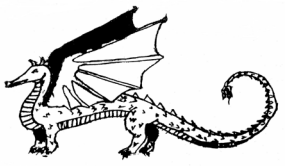
Student Printed Name: _____

Parent Acknowledgment:

As the parent or legal guardian of the minor student signing above, I grant permission for my student to access networked computer services such as electronic mail and the Internet. I understand that individuals and families will be held liable for violations. I understand that some materials on the Internet may be objectionable and I accept responsibility for guidance of Internet use and conveying standards for my student to follow when selecting, sharing or exploring information and media. I also understand that I will be held financially responsible for all repair and/or labor costs for damages that may occur as a result of my son or daughter's misuse of the computer hardware, software, data or Internet related activities.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____



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PARENT RELEASE FORM FOR MEDIA RECORDING

I, the undersigned, do hereby grant or deny permission to 21st Century Public Academy to use the image of my child,_____as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child for use in the materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the 21st Century Public Academy website.

☐ Deny permission

☐ Grant permission (mark all that apply)

- ☐ Limited usage: I allow within the 21st Century Public Academy setting only (not in the larger community).
- ☐ Limited usage: I allow educational materials only (not marketing). This could be either within 21st Century Public Academy or in the larger community. One example of this could be videos in parent education classes.
- ☐ Limited usage: I allow on printed materials only (no digital or video use)
- ☐ Unrestricted usage: I give unrestricted permission for use in print, video, and digital media related to 21st Century Public Academy without further notification. I do understand that the child's last name will not be used in conjunction with any video or digital images.

Parent/guardian signature: _____ Date: _____

If you have questions, please contact Ms. Morga at 254-0280.

Special Education/Gifted Information

Students Name_____ DOB_____
Grade Level (2018-2019) _____ Student ID #_____
Services required – please check all that apply:

- ❒ Gifted
- ❒ OT – Occupational Therapy
- ❒ PT – Physical Therapy
- ❒ RT – Recreational Therapy
- ❒ SW – Social Work
- ❒ Speech & Language
- ❒ Other: _____

Please turn in a copy of your Students IEP, Evaluations, or 504 plans to 21st Century Public Academy by May 6th, 2018.

_____ _____

Parent Date

_____ _____

Parent Signature Phone #

_____

Parent Email

_____ _____

Date Received at 21st Century Staff Member

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Health/Emergency Information 2018-2019

Name	Birth Date	Grade	Teacher
Student Address		Home Phone	
Father's Name		Cell Phone	Work Phone
Mother's Name		Cell Phone	Work Phone
Lives With		Home Phone	Work Phone

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Doctor	Phone
Dentist	Phone
Nurse Practitioner/Physician Assistant	Phone
Hospital	Phone

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Signature of Parent/Guardian	Date

PLEASE COMPLETE BOTH SIDES OF FORM

Condition	Year/Age Condition Occurred	Condition	Year/Age Condition Occurred
Asthma		Meningitis	
Diabetes		Migraine Headaches	
Ear/Hearing Problems	Type:	Muscular Weakness or Paralysis	
Emotional Problems	Type:	Bleeding Disorders	Type:
Seizures		High Blood Pressure	
Heart Problems		Infectious Diseases	Type:
Hepatitis	Type:	Tetanus Shot	Date:

Other:		
Allergies:		
Reactions to Medicine or Injections?		
Hospitalized for Serious Illness, Surgery, or Accidents? (If yes, explain)		
Long Term Medications?		
Use of Contact Lenses? (Circle One)	Yes	No
Have you ever been informed of the need to be on antibiotic therapy prior to dental treatment? If Yes, identify required therapy:	Yes	No
Please add any problems not listed:		

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Registration Form 2018-2019

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Street or Rural Address, with Zip Code	Home Telephone

Student's Birthplace (Country Only)	If not USA, years in country	Date of Birth

STUDENT ETHNICITY: Enter the number of the student's ethnicity from the list below. A second ethnicity may be entered if appropriate. 1 = Anglo 4 = American Indian or Alaska Native 2 = African American/Black 5 = Asian or Pacific Islander 3 = Hispanic 6 = Other (write ethnicity in box)	Ethnicity Tribe (if 4)	Second Ethnicity

PRESCHOOL CATEGORY: What type of preschool did the student attend? Enter the letter from the list below. A = Did not attend preschool C = Public preschool B = Private preschool D = Headstart program	Preschool Category

School Last Attended	Address, City, State, Zip (if not an APS school)	Date Last Attended

Has your family moved in the past 36 months to another city or state to pick crops, weed fields, work on ranches or work in canneries? (Yes/No)	

	Last Name	First Name	M.I	Living with this person	Legal guardian	Home Phone	Cell Phone
MOTHER							
	Street Address Email address:			Zip Code	Employer Active Military: Y/N Work Phone:		
FATHER	Last Name	First Name	M.I.	Living with this person	Legal guardian	Home Phone	Cell Phone
	Street Address Email address:			Zip Code	Employer Active Military: Y/N Work Phone:		

If other than mother or father, person with whom student lives	Last Name	First Name	M.I.		Legal guardian	Home Phone	Work Phone
	Street Address			Zip Code	Employer		

Emergency Contact	Phone #	Family Physician	Phone #

Is student covered by health insurance?	Insurance Company	Is student covered by Medicaid?	Medicaid number

PLEASE COMPLETE BOTH SIDES OF FORM

Name of each school age child			School	Grade	Emergency Phone #	Date of Birth		
Last Name	First Name	M.I				Month	Day	Year

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2. What language(s) does your child use most often at home?_____

   _____

3. What languages are commonly used in speaking with your child?_____

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4. What language do you prefer to use when contacted by the school?_____

   _____

_____ _____

Parent Signature Date