

WELCOME TO

NORDONIA HILLS
CITY SCHOOL DISTRICT



Joe Clark, Ph.D.
Superintendent

NORDONIA HILLS CITY SCHOOLS
PreK REGISTRATION PACKET

Nordonia Hills Board of Education
9370 Olde Eight Road
Northfield, OH 44067

Please call for a Registration Appointment 330-467-0580

BRING WITH YOU:

- Parent/Guardian Driver's License/State I.D.**
- Original Certified Birth Certificate**
- Immunization Records**
- Social Security Card**
- Custody Papers (if applicable, court stamped & signed order)**
- Special Education/Special Needs, I.E.P., E.T.R., M.F.E., 504 Plan (if applicable)**
- Proof of Residency (NO utility bills, see below)**
(Lease/Purchase Agreement or Building Contract or Deed)
- COMPLETED FORMS**
 - **Pupil Registration Record Card**
 - **Home Language Survey**
 - **Emergency Sheet**



**NORDONIA HILLS CITY SCHOOL DISTRICT
PUPIL REGISTRATION RECORD
Building: LV**

For Office Use Only	
Entry Grade _____	
Student ID# _____	
Date Transcript Sent For _____	

STUDENT DATA: (TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN)

Student Legal Name _____ Phone Number w/Area Code _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Place of Birth: City _____ State _____ Sex: M _____ F _____

Information regarding Ethnicity is required by the Ohio Department of Education

Is the Student of Hispanic/Latino Heritage (Circle one) Y N (Below please check all that apply)

Ethnic Origin: White _____ Black _____ Asian _____ Pacific Island/Hawaii _____ Amer. Indian/Alaskan Native _____

Previous School _____ City _____ State _____ Zip _____

Language Spoken by Student: _____ Language Spoken by Parent/Legal Guardian(s): _____

Does your child have a current IEP? _____ 504 plan? _____

Does your child attend a special program? _____ Title 1 Reading _____ Tutoring _____ Other _____ (please specify)

Has your child ever been retained? _____ At what Grade Level? _____ Former student of Nordonia Schools? _____

HEALTH DATA: Known or suspected conditions: (please check any that apply)

Heart Condition _____ Medication Required? _____ Name/Type of Medication _____

Seizure Disorder _____ Medication Required? _____ Name/Type of Medication _____

Diabetes _____ Medication Required? _____ Name/Type of Medication _____

Severe Allergies _____ Medication Required? _____ Name/Type of Medication _____

Vision _____ Glasses: Yes _____ No _____ Hearing _____ Aid(s): Yes _____ No _____

Other _____

FAMILY DATA: (With Whom the Student Resides)

Email Address: _____

(Circle one) Father/Legal Guardian, Other: _____

(Circle one) Mother/Legal Guardian, Other: _____

Name _____

Name _____

Name of Employer _____ Occupation _____

Name of Employer _____ Occupation _____

Employer's Address _____

Employer's Address _____

Work Phone w/Area Code _____

Work Phone w/Area Code _____

Mother's Status: (check as many as apply) Married ___ Single ___ Widowed ___ Separated ___ Divorced ___ Remarried ___ Deceased ___

Father's Status: (check as many as apply) Married ___ Single ___ Widowed ___ Separated ___ Divorced ___ Remarried ___ Deceased ___

Shared Parenting ___ If checked, include information for other parent: Name _____

Address _____ Phone w/Area Code _____

Student's Brothers (in district)

Student's Sisters (in district)

(Name) (Birthdate) (School)

(Name) (Birthdate) (School)

State Law requires that school districts have documents on file by the first day of attendance, when a divorce or separation exists.

Currently in litigation date filed _____ (only valid for 60 days from file date)

Date Finalized Judgement/Journal/Probate Letter _____

Journal # _____ Final Custody Papers must be on file with the school by _____ the first day of attendance.

Signature of Parent/Guardian _____ Date _____

NORDONIA HILLS CITY SCHOOL DISTRICT
STUDENT CONTACT/EMA FORM
PLEASE CONTACT THE SCHOOL IMMEDIATELY IF ANY INFORMATION CHANGES

Student's Last Name _____ Student's First Name _____ Gender _____

Student resides with Both Parents Mother Father Guardian Foster Date of Birth _____
 Are current custody papers on file with the school (CHECK ONE) Yes _____ No _____
 CUSTODY ALERTS (court ordered) _____ Shared Parenting

Mother/Guardian's Last Name _____ **Home #** _____
Mother/Guardian's First Name _____ **Work #** _____
Address _____ **Cell #** _____
City, Zip _____
Email Address _____
Employer _____
Las Name _____ **Home #** _____
Father/Guardian's First Name _____ **Work #** _____
Address _____ **Cell #** _____
City, Zip _____
Email Address _____
Employer _____

Phone Contact Information

Only the Primary contact numbers listed below will be used for Special Announcements and Emergency Calls through the phone contact calling system.
 (Please list only one number)

Primary # (All calls) _____
 Relationship _____

OTHER CONTACTS The following names will only be called when the student's mother/father/guardian cannot be reached. They are authorized to pick up your student due to emergency situations such as illness, school evacuation, or any other type of dismissal.

Other Contacts

Name	Relationship	Phone	Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature of Mother/Father/Guardian (Approving information listed above) _____ Date _____

PLEASE CONTACT THE SCHOOL IMMEDIATELY IF ANY INFORMATION CHANGES
EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable mother/father/guardian to authorize the provision of emergency treatment for students who become ill or injured while under school authority, when mother/father/guardian cannot be reached.

****YOU MUST CHOOSE BETWEEN FILLING OUT PART 1 OR PART 2****

PART 1 (TO GRANT CONSENT)

I hereby grant consent for the following medical care providers and local hospital to be called:

DOCTOR/PHONE _____ **LOCAL** _____
HOSPITAL/EMERGENCY/PHONE _____
DENTIST/PHONE _____ **MEDICAL** _____
SPECIALIST/PHONE _____

In the event that 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. This authorization does not cover major surgery unless the medical opinions of two 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 medical concerns and/or allergies to which physicians should be alerted: _____

Signature of Mother/Father/Guardian (Approving Information listed above) _____ Date _____

PART 2 (REFUSAL TO CONSENT) *DO NOT COMPLETE PART 2 IF YOU COMPLETED PART 1**

I do **NOT** give my consent for emergency treatment of my child in the event of illness requiring emergency treatment. I wish the school authorities to take **NO** action or to _____

Signature of Mother/Father/Guardian (Approving Information listed above) _____ Date _____