

## Student Enrollment Requirements

- Birth Certificate
- Family Information Form
- Emergency Contact Form
- Student Health Information Form
- Medication Permission Form (if applicable)
- School, Social Media and News Opt-Out Form

- **Current immunization Records**

\*In accordance with Arizona State Law, students must have proof of all required immunizations, or a valid exemption, in order to attend school. The immunization record must include the child's name, date of birth, and each vaccine dose must include the date and the name of the physician or health agency who administered the vaccine.

*\*Enrollment is not complete until all forms are received, and the \$100 non-refundable new student registration fee has been received.*

## Family Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Last

First

MI

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender  Male  Female

Current Grade: \_\_\_\_\_ Entering Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

Zip Code

**Parent/Guardian Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

Zip Code

Email Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Home Phone

Work Phone

Cell Phone

Emergency Contact: \_\_\_\_\_

Name

Home Number

Cell Phone

**Parent/Guardian Name:** \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

Zip Code

Email Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Home Phone

Work Phone

Cell Phone

Emergency Contact: \_\_\_\_\_

Name

Home Number

Cell Phone

## Family Information Continued

### Special Needs:

*\*If you answer "YES" to any of the questions below, please explain below attach a written description of the special needs.*

Does the student have any health conditions that may affect educational needs?

Explain: \_\_\_\_\_  
\_\_\_\_\_

Yes

No

Does the student have a disability that may affect educational needs?

Explain: \_\_\_\_\_  
\_\_\_\_\_

Yes

No

Does the student have any mobility impairments?

Explain: \_\_\_\_\_  
\_\_\_\_\_

Yes

No

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_

Last

First

MI

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

Zip Code

### 1<sup>st</sup> Emergency Contact

Name: \_\_\_\_\_

Last

First

MI

Address: \_\_\_\_\_

Street

City

Zip Code

Phone: \_\_\_\_\_

Home Phone

Work Phone

Cell Phone

### 2<sup>nd</sup> Emergency Contact

Name: \_\_\_\_\_

Last

First

MI

Address: \_\_\_\_\_

Street

City

Zip Code

Phone: \_\_\_\_\_

Home Phone

Work Phone

Cell Phone

|                                    |
|------------------------------------|
| Student Name: _____<br>Date: _____ |
|------------------------------------|

## Emergency Contact Continued

In the event of serious illness or injury occurring within the jurisdiction of AZ Aspire Academy, the school will first attempt to reach you and/or your physician.

As parent/guardian, I consent to have my child receive first aid by facility staff and, if necessary, be transported to receive emergency care. I will be responsible for all charges not covered by insurance. I consent for the emergency contact person(s) listed below to **ACT ON MY BEHALF** until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months.

**IN THE EVENT OF AN EMERGENCY WHEN PARENT/GUARDIAN IS NOT AVAILABLE, PLEASE CONTACT:**

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|      |              |       |
|------|--------------|-------|
| Name | Relationship | Phone |
|------|--------------|-------|

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|      |              |       |
|------|--------------|-------|
| Name | Relationship | Phone |
|------|--------------|-------|

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|      |              |       |
|------|--------------|-------|
| Name | Relationship | Phone |
|------|--------------|-------|

*By signing this form, ALL people listed above will also have permission to pick up my child from school (photo ID required)*

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**Parent/Guardian Signature**

**Date**

Student Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Student Health Information

Student Name: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

In Case of emergency, AZ Aspire Academy will attempt to contact a parent/guardian before calling the student's primary health care provider. Your child will be transported by ambulance to an emergency care facility if necessary.

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Please check all that apply to your child:

Heart Condition     Diabetes     Asthma     Migraines     Seizure Disorder

Other: \_\_\_\_\_

\_\_\_\_\_

*\*Please complete medication form if any treatment is required for any of the above conditions*

### Allergies:

Food:

\_\_\_\_\_  
\_\_\_\_\_

Environmental:

\_\_\_\_\_  
\_\_\_\_\_

Medication:

\_\_\_\_\_  
\_\_\_\_\_

Insects:

\_\_\_\_\_  
\_\_\_\_\_

*\*Please complete medication form if any treatment is required for any allergies*

Hearing impairments/limitations: \_\_\_\_\_

Vision impairments/limitations: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Permission for Prescribed Medication

Student Name: \_\_\_\_\_

Student Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date form received: (To be completed by school personnel): \_\_\_\_\_

### TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Form of medication/treatment:  Tablet/capsule  Liquid  Inhaler  Injection  Nebulizer

Other: \_\_\_\_\_

Instructions (Schedule and dose to be given at school): \_\_\_\_\_

\_\_\_\_\_

Special Storage Requirements:  None  Refrigerate  Locked Cabinet  Other: \_\_\_\_\_

\_\_\_\_\_

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Physician's Signature

\_\_\_\_\_

Date

Student Name: \_\_\_\_\_

Date: \_\_\_\_\_

\*\*\*FOR SELF-ADMINISTRATION ONLY\*\*\*

This student has been instructed on self-administration of this medication: for asthmatic, diabetic or severe allergic reaction(anaphylaxis) ONLY.

No

Supervision required

Supervision not required

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Physician or Authorized Provider*

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) \_\_\_\_\_ to receive the above stated medication at school according to standard school policy. I release AZ Aspire Academy and its employees from any claims or liability connected with its reliance on this permission.

(Parent/guardians to bring the medication in its original container)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Home Phone

Work Phone

Cell Phone

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Social Media and News Opt-Out Form

Part of the communication efforts of AZ Aspire Academy is to let the general public know about the educational activities occurring within the walls of our schools. As part of that effort, we also occasionally invite reporters to the schools to cover educational activities and events. The main focus of education, of course, is students, and during the vast majority of time, we and the media will want to focus on students as the subject of stories. For that reason, we are seeking your permission ahead of time for your student(s) to be interviewed, photographed or videotaped in the event such an opportunity surfaces during the school year. This will include the use of that material on the school website and social media managed by AZ Aspire Academy. Please note, AZ Aspire Academy policy prevents use of a child's full name in association with their photo or video in any form of use.

If you **DO NOT** want your student to be involved in one or all of these instances, please fill out this form and return it to the school. Please note, your permission will be assumed if the school does not receive this form. Please indicate which instances you would like to opt out of:

\_\_\_\_ My child may NOT be photographed or videotaped, for use by AZ Aspire Academy.

\_\_\_\_ My child may NOT be photographed, videotaped and interviewed by an outside entity.

Student Name: \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



|                     |
|---------------------|
| Student Name: _____ |
| Date: _____         |

## Parent Funding Options

### **Empowerment Scholarship Accounts**

An Empowerment Scholarship Account (ESA) is an account established through the Arizona Department of Education to provide a private school education for *qualified students*. Please go to the following website for further details and information:

<http://www.azed.gov/esa>

### **School Tuition Organization**

A School tuition organization (STO) is one that is tax exempt under Section 501(c)(3) of the Internal Revenue Code and allocates at least 90% of its annual revenue to scholarships or grants and makes its scholarships/grants available to students of more than one qualified school.

**\*\*Please contact us for further details and information regarding scholarship and funding opportunities\*\***