

MARSS # _____ Student Local #: _____ LLA Code: _____ Starting Date: _____ HR Teacher: _____

NOBLE ACADEMY ENROLLMENT FORM 2011-2012**STUDENT INFORMATION**

First name:	Last :	Middle:	Age:	Gender: <input type="checkbox"/> M or <input type="checkbox"/> F
Date of birth:	SSN:	Home Phone:	Cell Phone:	
Current address:			Apt/Unit #	
City:	State:	ZIP Code:		
Place of Birth:	Immigrant? <input type="checkbox"/> Yes or <input type="checkbox"/> No (Optional)	Current Grade: _____		Grade for Fall Of 2011-2012: _____
Has this child previously attend Noble Academy: <input type="checkbox"/> Yes or <input type="checkbox"/> NO		Date of arrival to US: _____		

ADDITIONAL INFORMATION ABOUT THE STUDENTRacial/ Ethnic Heritage: American Indian Asian Hispanic African American African Caucasian Other:

Name of last school attended:	School Phone:	School Fax:
Address of previous school:	City:	State:
Has this child repeated a grade? <input type="checkbox"/> Yes or <input type="checkbox"/> No	If yes, which grade:	

Home Language Questionnaire

1. Is your child bi-lingual Yes or No
2. Which language did your child learn first? _____
3. Which language is most often spoken at home?

4. Which language does your child usually speak?

Is your child receiving any of the following services?

(check all that apply)

- Title I Speech/ Language Special Education? IEP or 504
 ELL Services On Medication Talented/Gifted
 Uncertain None Other

Please explain any special needs this child may have (be very specific):

List siblings (name/grade) currently at Noble Academy:

PARENTS/ GUARDIAN INFORMATION

Child lives with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparents <input type="checkbox"/> Other _____	
Mother's Name:	Mother's daytime phone:
Mother's Employer:	Work phone:
Mother's email address:	
Father's Name:	Father's daytime phone:
Father's Employer:	Work phone:
Father's email address:	
Guardian's Name:	Daytime Phone:
Guardian's Name:	Daytime Phone:

Comments:

SIGNATURE

All data on this form is private and will be used by authorized school personnel to identify the student's school record, provide legally required data for state reports, and to enable school to communicate with the home. Parents/guardians are responsible for updating information to the school as it changes. I have read the above statement, and I agree to supply the data on this form with full knowledge of the information provided in that statement. I hereby certify that all information is true and correct to the best of my knowledge. I understand that any false or misrepresented information will necessitate further District action.

PARENT/GUARDIAN SIGNATURE: _____

PRINT NAME: _____

DATE: _____

CONFIDENTIAL EMERGENCY HEALTH INFORMATION
School Year 2011-2012

Please complete BOTH sides of this form and return to Noble Academy

First Name: _____ Last Name: _____ Middle Initial: _____

Birthday: _____ Grade: _____ Sex: M F

ALERT TO PARENTS: If your child has a serious medical condition, *it is vital that you discuss this with the school personnel and teacher(s) immediately.* It is very important to know of **LIFE THREATENING** conditions (for example asthma, diabetes, nut/insect allergies).

In order to provide a safe and healthy environment for your child, this information will be accessible to the following people: School Nurse, your child's teacher, office manager, personnel responsible for health room coverage and emergency medical personnel.

A. Medical History: Check the ones that apply to your child and describe under the comment section.

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anxiety/Panic attack | <input type="checkbox"/> Hearing Problem | (explain) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> PE activity |
| <input type="checkbox"/> Bee Sting allergy | <input type="checkbox"/> Kidney/urinary | Limited _____ |
| <input type="checkbox"/> Bowel problem | problems | Not Limited _____ |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Muscle Disorder | Explain: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Concern | _____ |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Orthopedic problem | _____ |
| <input type="checkbox"/> Epi-Pen | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Emotional Concerns | <input type="checkbox"/> Vision problems | _____ |

Comments: _____

B. ALLERGIES: List allergies your child has that cause a problem at school:

Cause of the allergy: _____ Treatment: _____
Cause of the allergy: _____ Treatment: _____

C. MEDICATION: (Include prescription, over-the-counter and herbal medication.)

Name	Used to treat	Taken at school?
1) _____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
2) _____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
3) _____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

Before medication of any kind can be administered at school, a medication administration form, available in the office, must be completed by parent and physician and kept on file.

D. List any other operations, injuries, hospitalizations. Give dates: _____

E. Does your student wear contact lens? _____ Glasses? _____

F. Name of Physician: _____ Phone: _____
Name of Dentist: _____ Phone: _____

(Over)

Name: _____ Birthday: _____ Grade: _____
Last First MI

G. Parents name: _____
(Mother) (Father)

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Home address: _____

City/Zip: _____

Student lives with: Mother: _____ Father: _____ Both parents: _____

IN THE EVENT OF A MEDICAL EMERGENCY, IF A PARENT OR GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:

1.) Name: _____ Home Phone: _____ Cell Phone: _____

Relationship: _____

2.) Name: _____ Home Phone: _____ Cell Phone: _____

Relationship: _____

3.) Name: _____ Home Phone: _____ Cell Phone: _____

Relationship: _____

Parent/Guardian Signature: _____ Date: _____

**Please return this form to: Noble Academy
Attention: Mai Houa Vue
4021 Thomas Avenue North
MPLS, MN 55412**

Please do not fax this form in



Health Services for 2011-2012

Name: _____ Birthday: _____

The following items are used in the health office at Noble Academy. By completing this form you as the parent give full consent for Noble Academy to provide these services for your child when in need.

- Rubbing Alcohol-70% Isopropyl (for tropical use)
- Bactrian ointment (topical antibacterial ointment for cuts)
- Hand lotion/cream (for chapped and/or dry hand)
- First aid cream (for soothe and helps healing)

Yes, Noble Academy has my consent to provide the above services to my child when in need.

No, Noble Academy does not have my consent to provide the above services to my child.

2011-2012 STUDENT ALLERGIES

List **any** allergies that your child has that will interfere with his /her performance or learning at school.

1. _____
2. _____
3. _____

List any medications to be taken during school including prescription, over-the-counter, and herbal medicine.

1. _____
2. _____
3. _____

Before any medications can be administered at school, a medication administration form must be completed by parents and physician

IN CASE OF AN ACCIDENT OR SERIOUS ILLNESS, I ASK THAT NOBLE ACADEMY CONTACT ME IMMEDIATELY. IF I CANNOT BE REACHED, I AUTHORIZE NOBLE ACADEMY TO ARRANGE FOR CARE AS NEED.

Print Name: _____

Phone Number: _____

Signature: _____

Date: _____

Application for Educational Benefits

Free and Reduced-Price School Meals • School Year 2010-11 • State and Federally Funded Programs for Schools

- Check here if this is the first school meal application at this school district or this nonpublic school for any child listed below.
- I have listed below **All children in the household** except foster children, from birth through high school. Attach an additional page, if necessary. (check one): **One foster child** in my care (who is the legal responsibility of a social services agency or court). Write in the foster child's name, date of birth, grade and school below. Does this foster child receive foster care funds that are designated specifically for the child's personal use? No Yes - \$_____. Complete a separate application for each foster child. Do not combine foster children and other children on this form.

Names of all Children in Household except Foster Children (or Name of One Foster Child)		Date of Birth Month/Day/Year	Grade	School	If applicable Regular Income to Child (for example SSI)
First Name	Last Name				
		___/___/___			\$_____ per _____
		___/___/___			\$_____ per _____
		___/___/___			\$_____ per _____
		___/___/___			\$_____ per _____
		___/___/___			\$_____ per _____

3. If applicable
Active Case Number
For any household member

Case Number: _____

MFIP
 Food Support (Stamps)
 FDPPIR
(Not Medical Assistance)

- List all adults in the household, all incomes and how often each income is received. Attach an additional page, if necessary. The instructions page shows the maximum income to qualify for school meal benefits. Do not complete Section 4 if a foster child is listed in Section 2 or a case number is provided in Section 3.

Names of all Adults in Household (all household members not listed in Section 2)		Check this column if person has NO INCOME	Household Incomes				
First Name	Last Name		Write in each gross income and how often it is received: weekly (W) , bi-weekly (BW) , twice per month (TM) , monthly (M) or yearly (Y) . Do not write in hourly pay. If income fluctuates, write in the amount normally received.				
			Gross Wages and Salaries from all jobs - before deductions -	Pension, SSI, Retirement, Social Security	Public Assistance, Child Support, Alimony	Unemployment, Worker's Compensation, Strike Benefits	Any Other Income, including net Farm/ Self-Employment
			\$_____ per _____	\$_____ per _____	\$_____ per _____	\$_____ per _____	\$_____ per _____
			\$_____ per _____	\$_____ per _____	\$_____ per _____	\$_____ per _____	\$_____ per _____
			\$_____ per _____	\$_____ per _____	\$_____ per _____	\$_____ per _____	\$_____ per _____

- If your children are approved for school meal benefits, this information may be shared with MinnesotaCare and General Assistance Medical Care programs to identify children eligible for Minnesota health insurance programs. See back page for more information. Leave the boxes blank to allow sharing of information.

Do not share my information with the MinnesotaCare health insurance program. Do not share my information with the General Assistance Medical Care program.

6. I certify that the information provided on this application is true and correct and that I have reported all household members and all household incomes. Because federal and state funds may be paid on the basis of this information, I understand that school and state officials may verify the information, and that deliberate misrepresentation may subject me to prosecution under applicable laws.

Signature of Adult Household Member (required) _____ Print Name: _____ Date: _____

Social Security number (required if Part 3 is completed): _____ - _____ - _____ OR I don't have a Social Security number

Address: _____ City _____ Zip _____ Home Phone: _____ Work Phone: _____

Total Household Size: _____ Total Incomes: \$_____ per _____ **Office Use Only**

Or Household Is Categorically Eligible: _____ (MFIP/Food Assistance (Stamps)/FDPPIR)

Approved: Free _____ Reduced-Price _____ Temporary until _____, _____, _____

Denied: Incomplete _____ Income Too High _____ Other: _____

Signature of Determining Official: _____ Date: _____

Withdrawn: _____

Change Status To: _____ Reason: _____

Date Verification Sent: _____ Response Due: _____ 2nd Notice Sent: _____ **Office Use Only**

Result: No Change _____ Free to Reduced-Price _____ Free to Paid _____ Reduced-Price to Free _____ Reduced-Price to Paid _____

Reason for Change: Income _____ Household Size _____ Refused Cooperation _____ Other: _____

Date 'Notice of Change' Sent: _____

Signature of Verifying Official: _____ Date: _____

Social Security Number / Complete Application

The National School Lunch Act requires that unless an active MFIP, Food Stamp or FDPIR assistance number is supplied for your child or you are applying for a foster child, the household member signing the application must provide their Social Security number or indicate that they do not have a Social Security number. Provision of a Social Security number is not mandatory, but if a Social Security number is not given or an indication is not made that the signer does not have such a number, the application cannot be approved.

To be complete, an application based on public assistance must include children's names, assistance numbers and signature of an adult household member. A complete application based on household income must include the names of all household members, the amounts of income received by all adult household members, the signature of an adult household member and the Social Security number of the household member completing the application or an indication that they have no Social Security number. A complete application for a foster child must include the child's name, the amount of any income received for the child's personal use and the signature of an adult household member.

Verification

The school and the Minnesota Department of Education may use the information provided on this form in carrying out efforts to verify the correctness of household size and income and public assistance information stated on the application. These verification efforts may be carried out through program reviews, audits and investigations and may include contacting state agencies such as the Minnesota Departments of Economic Security, Human Services or Revenue to verify income or current approval for public assistance. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported.

Privacy of Information That You Provide on This Form

Information that you provide on this form is private data. The information is used to determine and verify whether children in your household qualify for free or reduced-price school meals and for administration and enforcement of the lunch and breakfast programs. We may share your information with education, health and nutrition programs to help them evaluate, fund or determine benefits for their programs; auditors for program reviews; and law enforcement officials to help them look into violations of program rules. The information you provide on this application is not released for any other purpose unless a parent or guardian requests the release in writing.

Privacy of Your Child's Eligibility Status

Your child's eligibility status for school meals (qualified for "free," "reduced-price" or "paid" meals) is private data used by the school officials who need to know the information to provide the correct school meal benefit to your child. At public school districts, each student's eligibility status is also recorded on a statewide computer system used to report student data to the Minnesota Department of Education as required by state law. The Minnesota Department of Education uses this information to: (1) administer state and federal programs; (2) calculate compensatory revenue for public schools; and, (3) judge the quality of the state's educational program.

Federal law allows a school to release a child's meal eligibility status to officials of the following types of programs without household consent: (1) federal education program; (2) state health or education program administered by the school or a state agency; and (3) federal, state or local nutrition program that has participation requirements similar to the National School Lunch Program. School officials may send information about other programs or benefits that may be of interest to households that have qualified for free or reduced-price school meals. School meal eligibility information is also used for statistical reports, without individual identification. A child's eligibility status will not be released for any other purpose unless a parent or guardian requests the release in writing.

Sharing Information with MinnesotaCare and General Assistance Medical Care Programs

Children who are eligible for free and reduced-price school meals may be eligible for Minnesota health insurance programs. Your child's eligibility status for school meals (qualified for free or reduced-price meals) may be shared with the MinnesotaCare and General Assistance Medical Care programs unless you tell us not to share your information by checking the boxes in section 5 of the application. You are not required to share information for this purpose and your decision will not affect approval for school meal benefits.

Civil Rights Survey (voluntary)

This information is requested solely for the purpose of determining compliance with federal civil rights laws, and will not affect your application. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner.

1. Ethnicity (check one):

Hispanic or Latino Not Hispanic or Latino

2. Race (check one or more):

American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander

Asian White

Black or African American

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. *In accordance with federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, D.C. 20250-9410 or call 1-800-795-3272 or 202-720-6382 (TTY). USDA is an equal opportunity provider and employer.*



Enrollment Check list

All forms must be completed thoroughly with signatures and dates and returned to Noble Academy. If you have any questions or concerns please call the main office. Registration must include the following forms:

- 1) Enrollment Application
- 2) Confidential Emergency Health Info
- 3) Health Services/Allergies Information Form
- 4) Transportation Information
- 5) Application for Educational Benefits
- 6) Pupil Immunization Record (Shot Records)
- 7) Birth Certificate (**Required**)
- 8) Social Security Number
- 9) **Kindergarten Only:** Kindergarten Physical (Must include Hearing and Vision Screening)
- 10) Any prior school information