James & Rosemary Phalen Leadership Academy
4352 Mitthoeffer Rd. * Indianapolis, IN. 46235
Phone: (317) 552-1600 Fax: (317) 225-4150

Enrollment Document Checklist
2018-2019

Enrollment process is NOT complete until all documents listed below are received & placed in the scholar's CUM file. If the documents have not been received, please contact the National Director of Enrollment, Uyvette Stepp at (317) 333-6980 x 1006.

Scholar Name:______________________________ **STN:**__________________________

- ☐ COMPLETED & SIGNED Enrollment Application (FRONT & BACK)
- ☐ COMPLETED & SIGNED Scholar Pick-Up & Emergency Release Authorization Form
- ☐ COMPLETED & SIGNED FERPA Consent Form
- ☐ COMPLETED & SIGNED Parent Compact
- ☐ COMPLETED & SIGNED Telephone Consumer Protection Act Form
- ☐ COMPLETED & SIGNED Free Lunch Application (**ALL** Families **MUST** Complete)
- ☐ COMPLETED & SIGNED Medication Consent Form
- ☐ Records Request Form & Copy of School Records from previous school
- ☐ Copy of parent(s) or guardian(s) State issued ID or Driver License
- ☐ Copy of Birth Certificate or Guardianship Documents
- ☐ Copy of IEP (IF applicable)
- ☐ Copy of Immunization Shot Records

Please contact me if you need any help or have any questions regarding enrollment documentation and or processes.

Uyvette Stepp
National Director of Enrollment

Initials:______

Date:________

Phalen Leadership Academy – Enrollment Application

Office Use Only
Scholar #__________ Grade______ GeoCode ________
Date Enrolled__________ Teacher __________

Scholar Information

Scholar Last Name	First Name	Middle Name	Gender ☐ Boy ☐ Girl

Scholar Date of Birth	Age	Grade	Place of Birth

Current Street Address	City	Zip Code
Mailing Address, *if different*	City	Zip Code

Home Phone ( )	Cell Phone ( )	Work Phone ( )

Parent E-mail Address

By Court Order, this child may not be legally released into the custody of:
(We will need a copy of this court order for our files) ____________________

Last School Attended

Name of School	Date Last Attended	Grade	City/County/State

Has Scholar previously attended a PLA school? * ☐ Yes ☐ No	Last School Entry Date

Family Information *(Write your First and Last Name)* — Check if Scholar lives with

Circle One

	Check if Scholar lives with ↓	
Father / Stepfather Foster / Caregiver / Guardian	☐	Phone Number
Mother / Stepmother Foster / Caregiver / Guardian	☐	Phone Number
Is Duplicate Mailing needed? If so, address		☐ Grades Only ☐ All Mail ☐ Spanish

Other Children Living At Home

Name (First and Last)	Date of Birth	Grade	School

Ethnic Origin *(Please check the primary group with which the Scholar most closely identifies)*

Ethnicity (Select One): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (Select One or More) Mark "1" for first, Mark "2" for second:

☐ American Indian/Alaskan	☐ Guamanian	☐ Korean	☐ Other Asian
☐ Asian Indian	☐ Filipino	☐ Laotian	☐ Other Pacific Islander
☐ Black, African American	☐ Hawaiian	☐ Tahitian	☐ White
☐ Cambodian	☐ Hmong	☐ Samoan	
☐ Chinese	☐ Japanese	☐ Vietnamese	

Scholar's First Language: ____________ Language(s) spoken at home: ____________

Health Information

Check all that apply: *(** please explain in "Comments")*

- ☐ Heart Problems **
- ☐ Physical Restrictions***
- ☐ Diet Restrictions***
- ☐ Seizures(☐ Medication Required***)
- ☐ Uses wheelchair, walker, crutches
- ☐ Allergies** (☐ Epi-Penneeded***)
- ☐ Diabetes (☐ Insulin Dependent***)
- ☐ Other illness, disability, special needs medications**
- ☐ Asthma Inhaler (Diagnosed by Doctor***)
- ☐ Diagnosed ADD/ADHD (Diagnosed by Doctor ***)

***Requires Doctor's Note/Completion of Doctor's Authorization Form**
Comments:

504 Plan
☐ ____________

Special Education

☐ **My Child HAS an IEP and is scheduled for Special Education Classes**

Please see below to log any of the areas of Special Education you see listed**:**

- ☐ Resource Specialist Program
- ☐ Special Day Class
- ☐ Autistic
- ☐ Severely Handicapped
- ☐ Emotionally Disturbed
- ☐ Visually Handicapped
- ☐ Orthopedically Handicapped
- ☐ Deaf/Hard of Hearing
- ☐ Speech/Language Impaired
- ☐ Specific Learning Disabilities
- ☐ District Program
- ☐ County Program
- ☐ Non-Public School
- ☐ **My Child has Never attended or been scheduled for Special Education Classes**

Past Behavior History

- ☐ My child **has not** been expelled from a public/private school or district*
- ☐ My child **has** been expelled from a public/private school or district*
- ☐ My child **is currently** being referred for expulsion from a public/private school or district*
- ☐ My child **has not** previously been suspended from a public/private school or district*
- ☐ My child **has** previously been suspended from a public/private school.*

My signature certifies that all information provided on this form is accurate. I understand that changes in address, telephone numbers, and/or emergency information must be reported to the school within 24 hours for the safety of my child.

Parent Signature: ____________________

Date:

**Parents are required by law to divulge this information (EC48918)*

Phalen Leadership Academy – Enrollment Application

Office Use Only		
Scholar ID #______________	Grade_______	GeoCode _________
Date Enrolled______________	Teacher ____________________	

Scholar Last Name		Middle Name	Gender Boy Girl
Scholar Date of Birth	Age	Grade	Place of Birth
Current Street Address	City	Zip Code	
Parent/Guardian Name	Email	Relation to scholar	
Parent/Guardian Home Phone ( )	Parent/Guardian Cell Phone ( )	Parent/Guardian Work Phone ( )	

SCHOOL PROPERTY RESPONSIBILITY & ACKNOWLEDGMENT

LIABILITY

The parent/guardian/student may be held responsible for the cost to repair and/or Replace, at the date of incident, any school property, equipment or iPad/Technology Device, and accessories: **a)** not returned, **b)** intentionally damaged, **c)** lost or damaged because of negligence, **d)** stolen, but not reported to school and/or police by end of the next school day.

DAMAGED AND LOST OR STOLEN IPAD/TECHOLOGY DEVICES

- Users will report any damaged or lost iPad/Technology devices to school authorities.
- Users will bring damaged iPad/Technology devices to the office and fill out an incident report.
- If the iPad/Technology device is lost or stolen, the parent/student is required to file a police report in order to receive a replacement iPad/Technology device. Otherwise, replacement is the financial responsibility of the student/parent.
- Damaged iPad/Technology devices that are not in a district issued case will be the financial responsibility of the student/parent.

PARENTAL RESPONSIBILITY FOR BODILY INJURY AND PROPERTY DAMAGE IN INDIANA

Under Indiana Code. Section 34-31-7. a parent/guardian will be financially responsible for certain harm to a person or damage to property, stemming from a minor's conduct if: the parent or guardian has custody of the minor child, and the child is living with the parent or guardian. **Parent Initials: _______**

CONSENT TO RELESE PHOTO/IMAGE

As a parent or guardian of this student, I hereby consent to the use of photographs/videotape taken during the course of the school year for publicity, promotional and/or educational purposes (including publications, presentations or broadcasts via newspaper, TV, internet or other media sources). I do this with full knowledge and consent and waive all claims for compensation for use, or for damages.

_____Yes, I give consent for Phalen Leadership Academies to photograph my child for school purposes and/or at school events.

_____ No, I do not authorize Phalen Leadership Academies to photograph for my child for any event.

Parent Initials: ________

Parent Education Level

This information is for statistical/survey information only and will be kept confidential.

Please check the box that most closely pertains to ***parents/guardians:***

- ☐ Graduate school/post graduate training
- ☐ High School Graduate
- ☐ College Graduate
- ☐ Not a High School Graduate
- ☐ Some College (includes AA degree)
- ☐ Declined to State

Indiana Department of Education ~ English Learner Programs
http:www.doe.in.gov/achievement/English-learners

HOME LANGUAGE SURVEY

To be completed by parents upon scholar enrollment to determine scholar's status as language minority. The Civil Rights Act of 1964, Title VI, Language Minority Compliance Procedures, requires school districts and charter schools to determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students as outlined Plyler v. Doe, 457 U.S. 202 (1982).

What is the native language of the scholar? ___________________________________

What language(s) is spoken most often by the scholar?__________________________

What language(s) is spoken by the scholar in the home?_________________________

If a language other than English is indicated for any of the questions, the scholar is considered to be a language minority scholar. Once this determination has been made, the following must occur:

- English proficiency assessment, upon enrollment and annually thereafter, to assess level (1-5) of English proficiency and measure growth annually.

x ____

Signature of Parent/Guardian (All Authorizations)

Date:____

Scholar Pick-Up AND Emergency Release Authorization Form

Scholar Name:__________________________________ Teacher:____________________ Grade:______

Please list below **ALL** persons, **INCLUDING** parents/guardians, who are authorized to pick up your child from school and in the event of an emergency. NOTE: For your scholar's safety, **ALL** authorized persons will be asked for photo identification. Please inform the persons on the list in advance of this precautionary measure. Persons may be added to the list or removed at any time, please inform school of any changes to this form. **ALL** families **MUST** complete this form. Your scholar will **NOT** be released to anyone **NOT** authorized. Authorization will be determined based on this form submitted by the parent/guardian. It is the parent/guardian responsibility to keep this information current

Contact 1:	**Relation:**	**Phone Numbers:** **Cell:** **Home:** **Work:**
Contact 2:	**Relation:**	**Phone Numbers:** **Cell:** **Home:** **Work:**
Contact 3:	**Relation:**	**Phone Numbers:** **Cell:** **Home:** **Work:**
Contact 4:	**Relation:**	**Phone Numbers:** **Cell:** **Home:** **Work:**
Contact 5:	**Relation:**	**Phone Numbers:** **Cell:** **Home:** **Work:**

NOTE: In case I am/We are unable to be reached during an emergency, I/We hereby authorize a representative of the school, pursuant to the provisions of Family Code Section 6910, to act as any agent to consent to the giving of any and all medical dental, hospital or surgical care to the above name scholar. I certify that all information is accurate and that it is my responsibility to inform the school of any changes in residency, phone numbers or emergency release contacts.

Parent(s)/Guardian(s)Signature:____ Date: _______

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FERPA Consent Form

The Family Educational Rights and Privacy Act (FERPA) is a Federal law that protects the privacy of student education. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. FERPA gives parents certain rights with respect to their children's education records.

The purpose of this form is to provide consent to the disclosure of the following information and/or records to Phalen Leadership Academy staff for an internal review of educational records.

- Birth Certificate or Guardianship Documents
- Immunization Records
- Technology Agreement
- School Messenger Consent
- Enrollment Application
- Home Language Survey
- Student & Parent Compact Pledge
- Scholar Release & Emergency Release Authorization
- Updated Phone and Email Address

I, ____, (parent or guardian's name) do hereby grant permission to Phalen Leadership Academies staff members participating in the internal review to have full access to ____ records.
(Scholar's Name)

Parent(s)/Guardian(s) Signature: ______________________________

Relationship to Scholar: ______________________________

Contact Number/Email: ______________________________

Date: ______________________________

Phalen Leadership Academies
www.PhalenAcademies.org

Dear PLA Parent(s)/Guardian(s),

The Telephone Consumer Protection Act bars the use of automated calling systems such as School Messenger for non-emergency purposes without express written consent of individuals. Therefore, Phalen Leadership Academies-Indiana, Inc., will discontinue all non-emergency automated calls (including absence verification calls) until written consent of Parent(s)/Guardian(s) is obtained. Please review the permission slip below and indicate your approval to receive non-emergency messages via School Messenger. Upon receipt of this document, your account will be updated accordingly within the system as per your request. Parents(s)/Guardian(s) must sign and return a copy of the permission slip, no later than October 30th of the current school year. Failure to return the permission slip will result in a deactivation of the family's School Messenger Account. If you have questions about this notification, please contact the school Principal/Deans.

Scholar Name: ____

Parent(s)/Guardian(s) Name: _____________________________________

Preferred Contact Number: ______________________________________

Secondary Contact Number: ______________________________________

I give Phalen Leadership Academies-Indiana, Inc., permission to send non-emergency messages to the phone numbers listed above via call, text, email or by way of an automate dialing system, such as School Messenger.

Parent(s)/Guardian(s) Signature: _____________________________________

Phalen Leadership Academies

Request to Administer Medication to
STUDENT DURING THE SCHOOL DAY
2018-2019

If it becomes necessary for a student to take medication or receive treatment during the school day, the parent or guardian must complete this request form and staff must securely file it in the school office. If the medication or treatment is physician prescribed, the parent or guardian must submit a written prescription from the child's physician or the current pharmacy label with the request. A physician's order is also necessary for prescription samples that may have been released to student, or for any over-the-counter medication that is not recommended for children under age twelve.

All other over-the-counter medication must be in the original container labeled with the student's name and date of birth. Label instructions will be followed for all over-the-counter medicine unless otherwise prescribed by a physician.

This request is in effect for one school year and must be renewed annually or whenever there is a change in medication.

Parent's or Guardian's Authorization

I request that the medication described below be administered to my child/ward at the times specified during the school day. I will give the school the medication in its original container or current prescription bottle.

I understand that a parent or guardian will transport all medication to and from school for grades K-8. Medications must be picked up by the last day of school, or medications will be discarded.

I give my permission for my child in grades 9-12 to bring home any unused medication.

I understand that a separate form must be completed for each medication.

I understand that this medication will be administered to my child only by authorized staff members and will be kept in a secure location within the school nurse clinic.

____
Student's Name (Please Print)

Student's Date of Birth: ___/____/______
Month Day Year

____
Name of Medication

Prescribed________ Over-the-Counter__

____
Days Medication to be given

Times(s) to administer: _____a.m_____p.m.

____
Amount of Medication to be given

Lot # or Rx#____________________________

____
Purpose of Medication

Refrigeration Required? Yes______ No ______

____
Signature of Parent or Guardian

____
Date

____
Printed Name

_____________/_________________/___________
Phone: Home / Cell / Work

James & Rosemary Phalen Leadership Academy

2018-2019 Household Application for Free and Reduced Price School Meals

Complete one application per household. Please use a pen (not a pencil).

Prescribed by State Board of Accounts
School Form No. 521/2018

STEP 1 List ALL infants, children, and students up to grade 12 who are members of your household (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced Price School Meals** for more information.

	Child's First Name	MI	Child's Last Name	Student? Yes	Student? No	Only Students: Name of School Building	Only Students: Birthdate	Only Students: Grade	Living with parent or caretaker relative? Yes	Living with parent or caretaker relative? No	Foster Child	Homeless, Migrant, Runaway
1				☐	☐				☐	☐	☐	☐
2				☐	☐				☐	☐	☐	☐
3				☐	☐				☐	☐	☐	☐
4				☐	☐				☐	☐	☐	☐
5				☐	☐				☐	☐	☐	☐

Check all that apply

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP (Food Stamp) or TANF?

If NO > Go to STEP 3.

If YES > Write a case number here then go to STEP 4 (Do not complete STEP 3)

Case Number: / / / / / / / / /

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what to do here?

Please read **How to Apply for Free and Reduced Price School Meals** for more information.

The **Sources of Income for Children** section will help you with the **Child Income** question.

The **Sources of Income for Adults** section will help you with the **All Adult Household Members** section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all children in household listed in STEP 1 here.

Child income	How often? Weekly	Every 2 Wks	2x Month	Monthly
$	○	○	○	○

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report **total (gross) income before any taxes or deductions** for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

	Name of Adult Household Members (First and Last)	Earnings from Work	Weekly	Every 2 Wks	2x Month	Monthly	Public Assistance/ Child Support/Alimony	Weekly	Every 2 Wks	2x Month	Monthly	Pensions/Retirement/ All Other Income	Weekly	Every 2 Wks	2x Month	Monthly
1		$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
2		$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
3		$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
4		$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
5		$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

(How often? applies to each income column)

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X X X _ _ _ _

Check if no SSN ☐

STEP 4 Contact information and adult signature. Mail Completed Form To: 4352 Mitthoeffer Rd. Indianapolis, IN. 46235 Turn for Textbook Benefits

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Printed name of adult completing the form | Signature of adult completing the form | Today's date

Street Address (if available) | Apt # | City | State | Zip | Daytime Phone and Email (optional)

STEP 5 Other Benefits – This section does not need to be completed to receive free or reduced price meal benefits.

Do you want to receive **Textbook Assistance**?

◯ Yes — If yes, **sign to the right** →

◯ No

I certify that I am the parent/guardian of the child(ren) for whom application is being made. My signature below authorizes the release of information on this application for textbook assistance. I give up my right of confidentiality for this purpose only. This application information will be shared with the Indiana Family and Social Services Administration pursuant to I.C. 20-33-5-2 and I.C. 12-14-28-2, solely for purposes of complying with 45 C.F.R. Parts 260 and 265.

Signature of adult completing the form ____________ Today's date ____________

School Use Only:
Approved
Denied
Not Applicable

This application information may be shared with the Family and Social Services Administration for the purpose of identifying children who may qualify for free or low-cost health insurance under **Medicaid** or **Hoosier Healthwise**. If you want the application information shared for this purpose, please sign below. I certify I am the parent/guardian of the child(ren) for whom application is being made. I authorize the release of information for this purpose.

For information about Hoosier Healthwise health insurance, call 1-800-889-9949.

Signature of adult completing the form ____________ Today's date ____________

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (check one or more):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility 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.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

fax: (202) 690-7442; or

email: program.intake@usda.gov

This institution is an equal opportunity provider.

FOR SCHOOL USE ONLY – DO NOT WRITE BELOW THIS LINE			
INCOME CONVERSION to YEARLY:			
WEEKLY X 52	EVERY 2 WEEKS X 26	TWICE A MONTH X 24	MONTHLY X 12

ELIGIBILITY DETERMINATION

Income Eligibility: Total Household Size:______ Total Income:$___________ per: Weekly Every 2 Weeks Monthly Twice a Month Yearly
OR Categorical Eligibility: Food Stamps/TANF Migrant Homeless Runaway Foster
Eligibility Determination: Approved Free Approved Reduced Price Denied
Reason for Denial: Income Too High Incomplete Application Other______________________
Type of Eligibility Notification Provided (if denied, notification must be written): Verbal Written Date:__________
Signature of Determining Official: ____ Date:____________ Date Withdrawn: ______________

VERIFICATION

Confirmation Review Official: ____ Application Direct Verified? Yes No

Date Verification Notice Sent:________________ Date Response Due from Households:__________ Date Second Notice Sent (or N/A): _____________	Approval Based On: Food Stamps / TANF Case Number Household Size and Income Other _________	Verification Results: No Change Free to Reduced Free to Paid Reduced to Free Reduced to Paid	Reason for Change: Income:________________ Household Size: _________ Change in Food Stamps /TANF Did not respond Other: _________________	Date Notice of Change Sent:__________ Date Change Made:_________

Request for Appeal
Date Hearing Requested:_________________
Hearing Decision: _______________________

Verifying Official's Signature:____ Date:__________________________