

Maple Heights City Schools

ENROLLMENT OFFICE
5500 Clement Drive
Maple Heights, Ohio 44137

ENROLLMENT OFFICE

Phone: 216.587.3200, Ext. 1030 or 1031
Fax: 216.587.1615

CHANGE OF ADDRESS REGISTRATION PACKET

USE THIS PACKET FOR A CHANGE OF ADDRESS WITHIN THE CITY OF MAPLE HEIGHTS

This packet includes a student identification/registration form, an emergency medical form, and an affidavit of residency form. ALL forms must be thoroughly completed for each student you wish to enroll. All enrollments must be done by the LEGAL GUARDIAN of the student as defined by ORC 3313.64 (F)(1) through (5).

The following items are required to complete a change of address:

- ✓ **Ohio Driver's License or Ohio State I.D.**
- ✓ **Proof of Residency – At least three different, recently dated items showing your name at your current Maple Heights address will be required.** Such documents include, but are not limited to:

- | | |
|---|---|
| <input type="checkbox"/> Voter Registration Card | <input type="checkbox"/> Utility Bills |
| <input type="checkbox"/> Valid State Driver's License/I.D | <input type="checkbox"/> Cable/Cell Phone Bills |
| <input type="checkbox"/> City of Maple Hts. Occupancy Permit | <input type="checkbox"/> Bank Statement |
| <input type="checkbox"/> Mortgage Statement or Deed | <input type="checkbox"/> Credit Card Statements |
| <input type="checkbox"/> Section 8 Contract | <input type="checkbox"/> Pay Stub Renter's Insurance |
| <input type="checkbox"/> Valid Signed Lease | <input type="checkbox"/> County Benefit Vouchers |
| <input type="checkbox"/> Car/Home Insurance or Renter's Insurance | <input type="checkbox"/> Municipal Income Tax Records |

Please call the enrollment office at 587-3200, ext. 1030 or 1031 with any questions or concerns and to schedule your appointment.

- New
- Re-entry

Maple Heights City School District



STUDENT REGISTRATION FORM

School _____

Grade _____

Student Name	Last Name	First Name	Middle Name	Entry Grade
Social Security # <small>(optional)</small>	- -	Birth Date	/ /	Month Day Year
Student's Home Address	Number	Street	City	Zip Code
Parent/Guardian	Name		Phone Number	
Previous school attended <small>• Kindergarten include preschool if attended • Include homeschooling</small>	Name of School	School District	City	State

Is this student Hispanic/Latino? <input type="checkbox"/> No, not Hispanic/Latino <input type="checkbox"/> Yes, Hispanic/Latino	Race <small>(choose one or more)</small> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	How Identified: _____
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Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Citizenship <input type="checkbox"/> Dual National <input type="checkbox"/> Non-Resident Alien <input type="checkbox"/> Resident Alien <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Other please name: _____
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Birthplace City State Country	Native / Primary Language <input type="checkbox"/> English <input type="checkbox"/> Other please name: _____
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Student Lives With <small>(check all that apply)</small> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Parent <input type="checkbox"/> Other (explain): _____	<input type="checkbox"/> Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Self
Legal Custody <small>(check all that apply)</small> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent Court Journal Entry: (____ / ____ / ____) County: _____	<input type="checkbox"/> Guardian <input type="checkbox"/> CCDCFS <input type="checkbox"/> Other (explain): _____ <input type="checkbox"/> Probate Court <input type="checkbox"/> Juvenile Court Restrictions: _____ District Bearing Cost(for Foster Children only): _____

Is the child in gifted or Advanced Placement?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, describe services:
Does the child have a 504 plan?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, describe services:
Has the child ever had an IEP?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, list year of most recent evaluation:
If yes, do you have a copy of the IEP?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, indicate program:
Is the child suspended?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, from what district?
Is the child expelled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, from what district? End Date: _____

I do not consent to the release of email, home address, and home phone number for outreach purposes

PARENT(S) / GUARDIAN INFORMATION

STUDENT NAME: _____

Mother		<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Remarried	<input type="checkbox"/> Deceased
<input type="checkbox"/> Residential <input type="checkbox"/> Non-Residential		Dual Mailing: <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Name		First Name		
Number		Street		City		Zip Code	
Address							
Workplace				Email			
Home Phone			Work Phone			Cellular Phone	

Father		<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Remarried	<input type="checkbox"/> Deceased
<input type="checkbox"/> Residential <input type="checkbox"/> Non-Residential		Dual Mailing: <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Name		First Name		
Number		Street		City		Zip Code	
Address							
Workplace				Email			
Home Phone			Work Phone			Cellular Phone	

Legal Guardian		<input type="checkbox"/> Step Parent	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Other:			
Last Name		First Name					
Number		Street		City		Zip Code	
Address							
Workplace				Email			
Home Phone			Work Phone			Cellular Phone	
Social Worker (If Applicable):							

EMERGENCY CONTACT INFORMATION

Name		Relationship		Name		Relationship	
Telephone				Telephone			
Address				Address			
Email				Email			

PLEASE LIST ALL OTHER CHILDREN UNDER THE AGE OF 22 WHO LIVE AT THE HOME ADDRESS

Name	Grade	Date of Birth	Gender	Relationship To Student

I hereby certify, under penalty of perjury, that all of the information that I have given is correct in all respects to the best of my knowledge.

Date: _____ **Parent/Legal Guardian/Independent Student:** _____

Signature

Maple Heights City Schools Emergency Medical Authorization

Student Name _____ Grade _____ DOB _____

Address _____ Phone # _____ / _____

Please list all names and phone numbers of people we can call if your child becomes ill and needs to go home.

Mother's Name _____ Phone _____ / _____ / _____
Home Work Cell

Father's Name _____ Phone _____ / _____ / _____
Home Work Cell

Other Person's Name/Relationship _____

Address _____ Phone _____ / _____ / _____
Home Work Cell

Other Person's Name/Relationship _____

Address _____ Phone _____ / _____ / _____
Home Work Cell

Other Person's Name/Relationship _____

Address _____ Phone _____ / _____ / _____
Home Work Cell

PURPOSE: TO ENABLE PARENTS TO AUTHORIZE THE EMERGENCY TREATMENT FOR CHILDREN WHO BECOME ILL OR INJURED WHILE UNDER SCHOOL AUTHORITY WHEN PARENTS CANNOT BE REACHED.

PART I or PART II MUST BE COMPLETED!

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospitals to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Phone _____

In the event reasonable attempts to contact me at _____ or _____ at _____
phone number other parent phone number

have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. _____
preferred doctor or Dr. _____ preferred dentist, 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 _____ or any reasonably accessible.
Preferred hospital

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted _____

Date Signature of Parent Address

PART II – REFUSAL OF CONSENT

I DO NOT GIVE MY CONSENT for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take **NO** action or to: _____

Date Signature of Parent Address

Maple Heights City School District



RESIDENCY AND CUSTODY AFFIDAVIT

For the purpose of establishing school residence and custody (To be completed by parent or legal guardian)

SIGN ONLY AFTER CAREFULLY READING AND SIGNING IN THE PRESENCE OF A NOTARY

THE UNDERSIGNED, FIRST BEING DULY SWORN ACCORDING TO LAW, STATE THAT:

I, _____ certify that I am the custodial parent/legal guardian of
(Parent's or Legal Guardian's Full Name)

(Student's Name)

and that I have established residency at _____
(Street Number, Name, Apt. #) (City) (State) (Zip Code)

Date of Occupancy: _____ Lease End Date (if applicable): _____

I, _____, certify that I am a resident of the above residence located within **Maple Heights City School District**. The registrar has explained to me that legal residency is determined by certain conditions, among them are that mail delivery, voting residence, and payroll city tax deductions are based on the **Maple Heights City School District** address and also, that the residence where meals are taken, and where the resident parent sleeps must be at the **Maple Heights City School District residence**. This is the legal definition of residency for school purposes in Ohio. See Ohio Revised Code Sections 3301.121, 3313.66 through 3313.662.

List the names of **ALL** people, both adults and children, who reside at the above address. Also, please indicate their school (if applicable) and "status" (i.e., homeowner, lessee, renter, parent, guardian, student, preschooler, grandparent, etc.) Attach a separate piece of paper, if needed.

Last Name First Name School (If Applicable) Last Name First Name School (If Applicable)

Last Name First Name School (If Applicable) Last Name First Name School (If Applicable)

Last Name First Name School (If Applicable) Last Name First Name School (If Applicable)

Please read each statement and then place your initials to the left of the statement.

I/we certify that the information provided in this document and registration packet is true and no information has been withheld, concealed, or misrepresented for the purpose of circumventing the school attendance laws of the State of Ohio in order to enroll named students in the **Maple Heights City School District**

I/we understand that I/we are responsible for informing school officials of any change(s) in the residence of any parent, legal guardian, or other responsible adult. If I change my present address to another address that is within the **Maple Heights City School District**, I will **immediately** file another residency and custody affidavit with the enrollment office of the **Maple Heights City School District**. I further understand that if the above noted address ceases to be my legal residence and my new residence is outside the boundaries of the **Maple Heights City School District**, I will withdraw my child(ren) from the district and will enroll my child(ren) in the new district of residence.

