

I prefer my correspondence in:

- English  Spanish
- Other: \_\_\_\_\_

**LA Promise Charter Middle School #1**  
**202 W. 1st Street #160, Los Angeles, CA. 90012**  
**(213) 745-4928**



## STUDENT ENROLLMENT FORM

### STUDENT INFORMATION *(Please Print)*

Gender:  Male  Female  Transgender

Student's Legal Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Name) \_\_\_\_\_

Student Residence \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address *(If different)* \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Grade Level \_\_\_\_\_ Home Telephone (\_\_\_\_\_) \_\_\_\_\_ Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Birthplace: City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_  
(Month / Day / Year)

If born outside the United States, write the date of entry into the U.S. \_\_\_\_\_  
(Month / Day / Year)

Date student started school in the U.S.A. \_\_\_\_\_ Date student started school in California \_\_\_\_\_  
(Month / Day / Year) (Month / Day / Year)

### PREVIOUS ENROLLMENT INFORMATION *(Please Print)*

Last school of attendance \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State or Country \_\_\_\_\_ Zip \_\_\_\_\_ Date Left \_\_\_\_\_

Prior SSID \_\_\_\_\_ Last School Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Has student ever been enrolled in a LAs Promise School?  Yes  No

If yes: School \_\_\_\_\_ Grade \_\_\_\_\_

Has student ever been accelerated *(advanced a grade earlier than expected)*? Yes No Grade Level(s) \_\_\_\_\_

Has student ever been retained (repeated a grade level)?  Yes  No Grade Level(s) \_\_\_\_\_

Is student currently under an expulsion order?  Yes  No If yes, district & school: \_\_\_\_\_

Is expulsion pending?  Yes  No If yes, reason: \_\_\_\_\_

If yes, from which school/district? \_\_\_\_\_

Is student currently on Juvenile Probation?  Yes  No

### HOME LANGUAGE & ETHNICITY INFORMATION *(Please Answer All Questions)*

1) Has this student received any formal English language instruction (listening, speaking, reading, or writing)?  Yes  No

2) Which language did this student learn when he/she first began to talk? \_\_\_\_\_

3) Which language does this student most frequently use at home? \_\_\_\_\_

4) Which language do you use most frequently to speak to this student? \_\_\_\_\_

5) Which language is most often used by the adults at home? \_\_\_\_\_

6) Is the student Hispanic or Latino? *(Select only one)*  Yes  No

7) What is the student's race? *(Select one or more)*

- American Indian/Alaskan Native
- Asian
- Asian Indian
- African American or Black

- Cambodian
- Chinese
- Filipino
- Guamanian
- Japanese
- Korean
- Laotian
- Native Hawaiian
- Other Pacific Islander
- Other Asian
- Samoan
- Vietnamese
- White

### OFFICE USE ONLY

Room Number	Teacher	Initial Language Test Date	Home Language	Birth Verification	Residence Verified	Enrollment Date	Student Number	Student Name
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**SPECIALIZED PROGRAMS (Please Print)**

1. Was this student receiving special education services at his/her previous school?  Yes  No  
If yes, do you have a copy of the IEP with you?  Yes  No If yes, please check the appropriate box(es) below:  
 Resource Specialist Program (RSP)  Special Day  Class (SDC)  Speech  504 Other \_\_\_\_\_  
Has this child exited from a Special Education Program?  Yes  No
2. Was this child previously in a Specialized Program?  Yes  No  
If yes, please check the appropriate box(es) below:  
 GATE  English Learner  Migrant Education  Other \_\_\_\_\_

**HEALTH HISTORY (Please Print)**

Is child receiving medical treatment of any kind?  No  Yes What kind? \_\_\_\_\_  
Does child have a vision condition?  No  Yes Are glasses needed?  No  Yes  
Does child have a hearing condition?  No  Yes  
Please list any medical conditions this student may have: \_\_\_\_\_  
Please list any medications this student takes on a regular basis: \_\_\_\_\_  
Please list any allergies this student may have: \_\_\_\_\_

**EDUCATIONAL RIGHTS HOLDERS (Please Print)**

Check One:  Mother  Stepmother  Guardian  Foster  Other \_\_\_\_\_ Resides with Student  Yes  No  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Occupation \_\_\_\_\_ Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work  
Phone (\_\_\_\_) \_\_\_\_\_ Cellular Phone (\_\_\_\_) \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Education (Mark Highest Level)  Not a high school graduate  High school graduate  Some college (AA degree)  
 College graduate  Graduate school/post graduate training

Check One:  Father  Stepfather  Guardian  Foster  Other \_\_\_\_\_ Resides with Student  Yes  No  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Occupation \_\_\_\_\_ Company Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_ Cellular Phone (\_\_\_\_) \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Education (Mark Highest Level)  Not a high school graduate  High school graduate  Some college (AA degree)  
 College graduate  Graduate school/post graduate training

**Other Children Living in the Home**

Name \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_

**EMERGENCY INFORMATION (Other Than Parent/Legal Guardian(s) Above)**

List names of all people authorized to pick up child other than parent. Must be 18 years of age or older.

Name	Address & City	Telephone	Relationship

Preferred Doctor \_\_\_\_\_ Phone No. (\_\_\_\_) \_\_\_\_\_ Preferred Hospital \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_ Group No. \_\_\_\_\_ Policy No. \_\_\_\_\_

In the event of a medical emergency all costs of paramedic, transportation, hospitalization, and any examination, X-ray, or treatment provided shall be the responsibility of the parent or guardian.

**REGISTRATION SIGNATURE**

**I authorize the release of all educational records including special education records and verify that the information contained in this document is true and correct to the best of my knowledge.**

Parent/Guardian Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_



# Enroll. Get Care. Renew.

## Health Coverage All Year Long

### Health Coverage Options

#### Medi-Cal:

- ▶ Children—regardless of immigration status—foster youth, pregnant women, and legally present individuals—including those with DACA status—may be eligible for no- or low-cost Medi-Cal.
- ▶ Medi-Cal covers immunizations, checkups, specialists, vision and dental services, and more for children and youth at no- or low-cost.
- ▶ Medi-Cal enrollment is available year-round.

#### Covered California:

- ▶ Covered California is where legal residents of California can compare quality health plans and choose the one that works best for them.
- ▶ Based on income and family size, many Californians may qualify for financial assistance.
- ▶ Enroll during Open Enrollment or any time you experience a life-changing event, like losing your job or having a baby. You have 60 days from the event to complete enrollment.

**! Undocumented Families** visit: [www.allinforhealth.org/resources#Undocumented](http://www.allinforhealth.org/resources#Undocumented)  
*Immigration status information is kept private, protected, and secure. It will not be used by any immigration agency to enforce immigration laws, but only to determine eligibility for health programs.*

#### You and your family may qualify for financial help:

Household Size	If 2016 household income is less than...		If 2016 household income is between...
1	\$16,394	\$31,600	\$16,395 – \$47,080
2	\$22,107	\$42,613	\$22,108 – \$63,720
3	\$27,820	\$53,625	\$27,821 – \$80,360
4	\$33,534	\$64,638	\$33,535 – \$97,000
5	\$39,247	\$75,650	\$39,248 – \$113,640
6	\$44,960	\$86,662	\$44,961 – \$130,280
▶	Adults may be eligible for Medi-Cal	Children may be eligible for Medi-Cal	May be eligible for financial help to purchase insurance through Covered California

### Enroll.

Three ways to enroll in Medi-Cal and Covered California:

- [www.coveredca.com](http://www.coveredca.com)
- 1(800) 300-1506
- Find in-person help: [www.coveredca.com/get-help/local/](http://www.coveredca.com/get-help/local/)

### Get Care.

- ▶ Find a primary care doctor in your network.
- ▶ Schedule an annual checkup for you and your family.
- ▶ Make sure to take your child to the dentist.
- ▶ Pay your monthly premium if your plan requires it.

### Renew.

- ▶ Medi-Cal must be renewed every year. Medi-Cal will mail renewal packet. Complete and return. For help, contact your local Medi-Cal office or call 211.
- ▶ Health plans through Covered California must be renewed every year. Renewal information will be mailed at the end of the year, or contact Covered California at 1 (800) 300-1506.

For more information go to: [www.allinforhealth.org](http://www.allinforhealth.org)

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A PROJECT OF THE CHILDREN'S PARTNERSHIP