

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

Student Name

Student Number

Enrollment Date

Residence Verified

Birth Verification

Home Language

Initial Language Test Date

Teacher

Room Number

**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