Gallia County Local Schools
4836 State Route 325, Patriot, OH 45658
Phone 740-379-9085 Fax 740-379-9138
www.gallialocal.org
District IRN# 065680

REQUEST FOR ENROLLMENT RECORDS

_____ _____ ___/___/___ _____ _____
Student's Name Grade Date of Birth Age Gender

Please release the following records:

All standardized/state test/ACT scores *Copy of birth certificate and social security card*
*Current health/immunization records and **physical*** *Current schedule with current alpha/numerical grades*
Custody or court documents with school district education cost responsibility
UP TO DATE and SIGNED psychological reports, IEP, special education, and gifted records
Student's Ohio SSID# *Up to date transcript from **ALL** previous attended schools*

Previous School_____ Previous School District_____

Address_____ City_____ State_____ Zip_____

Phone_____ Fax_____ Previous School IRN#_____

GCLS Building to attend_____
Student attended AE___HTE___RVHS___RVM___SGHS___SGM___SWE___VE___SODA___

Primary Language_____ Native Language_____ SSN____/____/_____

Race/Ethnicity White___Black/African American_____Asian_____American Indian/Alaskan Native_____
Native Hawaiian/Pacific Islander_____Hispanic/Latina_____Other_____

Special Programs ETR___IEP___ Disability_____ 504 Plan___ Birth City/State_____,_____

Court/Foster Place___ Court Documents___ School District responsible for education_____

_____ _____ _____ _____
Guardian Name Guardian Name Parent Name Parent Name

_____ _____ _____ _____
Phone Phone Phone Phone

_____ _____ _____ _____
Email Email Email Email

_____ ___/___/___
Parent/Guardian Signature Date

Penny Coon
Administrative Assistant
gl_pcoon@gallialocal.org
Ext 10012

DATE ENTERED BUILDING/LOGGED ON ___/___/___

Gallia County Local Schools District
Confidential History Form

TODAY'S DATE _____ SCHOOL ENROLLING TODAY _____

STUDENT'S NAME: LAST _____ FIRST _____ MIDDLE _____

CURRENT GRADE: _____ DATE OF BIRTH ____/____/____ GENDER: M F

MOTHER'S NAME _____ PHONE: _____

FATHER'S NAME _____ PHONE: _____

CHILD LIVES WITH: MOTHER FATHER GRANDPARENT GUARDIAN OTHER _____

CHILD'S PRIMARY ADDRESS: _____

SIBLINGS AND AGES: _____ _____

_____ _____ _____

DOES YOUR CHILD HAVE: IEP YES NO 504 PLAN Y N SPECIAL EQUIPMENT Y N

DOES YOUR CHILD HAVE ALLERGIES (FOOD, MEDICATIONS, INSECTS, LATEX, ETC)? Y N

IF YES, PLEASE LIST ALLERGY AND TREATMENT _____

_____

Please list any medications/treatments this student requires daily (even if not needed at school): _____

_____

CHECK ANY OF THE FOLLOWING THAT APPLY TO THIS STUDENT:

☐ No Health Conditions	☐ Vision Impairments	☐ Digestive Issues	☐ MusculoSkeletal Issues
☐ ADHD/ADD	☐ amblyopia	☐ Eating Disorder	☐ Cystic Fibrosis
☐ Asthma	☐ wears glasses/contacts	☐ Menstrual Issues	☐ Mental Health Concerns
☐ Migraines/Headaches	☐ color vision deficits		☐ Learning Disabilities
☐ Diabetes	☐ Cardiac Issues	☐ Kidney Issues	☐ Hearing Issues
☐ Seizures	☐ High Blood Pressure	☐ Vascular Issues	☐ Liver Issues ☐ Hearing Aides R L

If you checked any of the above boxes, please describe the condition and current treatments:

_____

If this student has had accidents or surgery, please list the dates and nature of each:

_____

Please list any concerns not already listed that the school nurse/teacher need to address:

_____

Gallia County Local Schools District
Confidential History Form

I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact their learning.

I understand that for the safety of my student, or to provide for their educational achievement, the school nurse may need to share information about my child with the appropriate school staff and/or associated agencies. Under the regulations of FERPA (Family Education Rights and Privacy Act of 1974), this information shall be shared in confidential manner only as necessary. If I do not want information shared, I must request this in writing and file this request with the school nurse.

In order for a child to receive over the counter medication (such as Tylenol, Motrin), the parent/guardian will be contacted for permission to administer. Prescription medications, including inhalers and EpiPens, require completion of GCLS Authorization to Administer form by your physician and specific procedure for administering medication at school. Please ask for appropriate forms if needed.

This written validation will be in effect until otherwise noted or changed.

Signature of Parent/Guardian: _____ **Date:** _____