

**Coastal Grove Charter School
1897 S Street
Arcata, CA 95521**

Applications must be received by Friday March 8, 2019 at 4:00pm for inclusion in the enrollment lottery

Grade _____ School Year _____

Independent Study Male
Female

Student's LEGAL Name: _____ Date of Birth: _____
(From birth certificate) Last Name First Name Middle Name Mo./Day/Year

Parent/Guardian's First Name Last Name (_____) Home Phone (_____) Cell/Work Phone

Parent/Guardian's First Name Last Name (_____) Home Phone (_____) Cell/Work Phone

Mailing Address _____ City State Zip

Residence Address (IF DIFFERENT) _____ City State Zip

E-mail addresses: _____

Last School Attended: _____ Last Day of Attendance _____
Name of School City/State Phone No.

Student's Birthplace: _____ If not born in the U.S., what month/year did your child enter U.S.? ____/____
City/State/Country Mo./Year

Must answer both questions

ETHNICITY: Mark the ethnicity with which the student most closely identifies: Please check one:
 Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)
 Not Hispanic or Latino

WHAT IS YOUR CHILD'S RACE (Please check up to five racial categories) The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> American Indian or Alaskan Native (100)
(Person having origins in any of the original people of North and South America (including Central America) | <input type="checkbox"/> Korean (203)
<input type="checkbox"/> Vietnamese (204)
<input type="checkbox"/> Asian Indian (205)
<input type="checkbox"/> Laotian (206)
<input type="checkbox"/> Cambodian (207)
<input type="checkbox"/> Chinese (201)
<input type="checkbox"/> Japanese (202) | <input type="checkbox"/> Hawaiian (301)
<input type="checkbox"/> Guamanian (302)
<input type="checkbox"/> Samoan (303)
<input type="checkbox"/> Tahitian (304)
<input type="checkbox"/> Other Pacific Islander (399) | <input type="checkbox"/> African American or Black (600)
<input type="checkbox"/> White (700)
(Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East) |
|---|--|--|---|

HOME LANGUAGE SURVEY

Which language did your son/daughter learn when he/she first began to talk? _____

What language does your son/daughter most frequently use at home? _____

What language do you use most frequently to speak to your son/daughter? _____

Name the language most often spoken by the adults at home: _____

PARENT EDUCATION LEVEL: Check the response that describes the highest education level of either parent/guardian(s):

- | | | |
|---|--|---|
| <input type="checkbox"/> Not a high school graduate | <input type="checkbox"/> Some college (includes AA degree) | <input type="checkbox"/> Graduate school/post graduate training |
| <input type="checkbox"/> High school graduate | <input type="checkbox"/> College graduate | |

What special services has your child received? (Please check all boxes that apply)

- Special Education:** IEP/Resource (RSP) Special Day Class (SDC) Speech/Language 504 Accommodation Plan
Other: Gifted (GATE) Remedial Math Remedial Reading Counseling English Language Development
 Medical Health Plan

Has the student been suspended, expelled or is the student in the process of being suspended or expelled from any school? Yes No
If yes: Name of school: _____ Address: _____ Date: _____

RESIDENCE – where is your child/family currently living? (Federally mandated by NCLB: Please check appropriate box)

- In a single family permanent residence (house, apartment, condo, mobile home) in a motel/hotel
 Temporarily Doubled-up (sharing housing with other families/individuals due to economic hardship, loss, or other reasons)
 Unsheltered (car/campsite)
 Farm
 In a sheltered or transitional housing program

OTHER CHILDREN IN THE FAMILY:

First and Last Name	Relationship	Lives at Home	Date of Birth	Grade
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	_____

OTHER ADULTS IN THE HOME:

Name	Relationship	Name	Relationship
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HEALTH PROBLEMS (Check all that apply)

Diagnosed ADD or ADHD..... <input type="checkbox"/>	Epilepsy..... <input type="checkbox"/>
Asthma..... <input type="checkbox"/>	Eye Injury..... <input type="checkbox"/>
Bladder Problems..... <input type="checkbox"/>	Hypoglycemia..... <input type="checkbox"/>
Bleeding Disorder..... <input type="checkbox"/>	Frequent Nosebleeds..... <input type="checkbox"/>
Color Vision Deficiency..... <input type="checkbox"/>	Scoliosis..... <input type="checkbox"/>
Diabetes..... <input type="checkbox"/>	Seizure Disorder..... <input type="checkbox"/>
Eczema/Skin Trouble..... <input type="checkbox"/>	Chicken Pox..... <input type="checkbox"/>
History of Ear Problem..... <input type="checkbox"/>	Describe _____
Heart Problem..... <input type="checkbox"/>	Describe _____
Head Injury..... <input type="checkbox"/>	Describe _____
History of Fractures..... <input type="checkbox"/>	Describe _____
History of Hospitalization..... <input type="checkbox"/>	Describe _____
History of Surgery..... <input type="checkbox"/>	Describe _____
Known Hearing Loss..... <input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>
Known Vision Loss..... <input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>
Physical Limitations..... <input type="checkbox"/>	Describe _____
Wears Contact Lens..... <input type="checkbox"/>	
Wears Glasses..... <input type="checkbox"/>	For close work <input type="checkbox"/> For distance only <input type="checkbox"/> At all times <input type="checkbox"/>

Other or further details of above _____

ALLERGIES (Check all that apply) None:

Animals <input type="checkbox"/>	Drugs <input type="checkbox"/>	List specific item(s) student is allergic to: _____
Insects <input type="checkbox"/>	Food <input type="checkbox"/>	
Bee Stings <input type="checkbox"/>	Plants <input type="checkbox"/>	Describe allergic reaction and/or treatment: _____
	Other <input type="checkbox"/>	Explain: _____

CURRENT MEDICATION(S) No Yes Epi-Pen If medication is needed at school a medication consent form must be picked up from the office and completed by your doctor. Please list below:

Name of Medication(s)	Dosage	Time Taken	Purpose
_____	_____	_____	_____

MEDIA PERMISSION

I give permission for my student to be observed, interviewed, photographed and/or filmed when a representative of the school or media has been permitted by the principal or designee to be on campus. Yes No

EMERGENCY MEDICAL AUTHORIZATION

I am the parent/guardian of the above named student. In case I am unable to be reached during any emergency, I hereby authorize a representative of the school, pursuant to the provisions of Family Code Section 6910, to act as an agent to consent to the giving of any and all medical, dental, hospital or surgical care to the above named student.

I/We have reviewed this two page document and to the best of my/our knowledge, the information contained herein is true and complete. The undersigned declares under penalty of perjury that they are the parents or legal guardians of the above-named student and grant the above authorizations.

Date: _____ Signature of Parent/Guardian: _____

Date: _____ Signature of Parent/Guardian: _____