Parent/Guardian Signature and Date

_____

SunBridge Schools 2020-2021 Enrollment Form

1850 Airport Hwy Toledo OH, 43609

Student Information

_____ _____ _____

Last Name First Name Middle

_____

Apartment Complex Name

_____ _____

Street Address PO Box

_____ _____ _____ ○ Male ○ Female

City State Zip Code Gender

_____ _____ _____

Grade for 19-20 School Year Home Phone Number Student Birth Date

_____ _____

Mother's Maiden Name Student's Birth Place City

Student Residency

- ☐ Student lives in residence owned or rented by parents
- ☐ Student lives in a publicly operated shelter
- ☐ Student lives in a privately operated shelter
- ☐ Student lives with relatives or friends
- ☐ Student lives with friends or family other than parent/guardian
- ☐ Student lives with more than one family in a house or apartment
- ☐ Student lives in a hotel or motel

Does the living arrangement above result from a loss of housing or economic hardship? ☐Yes ☐No

Is the student of Hispanic/Latino heritage?

__ Yes ___ No

At least one race must be chosen below regardless if Yes or No was chosen above:

__ American Indian or Alaskan Native
__ Asian
__ Black or African American
__ White

Is the student a U.S. Citizen?

__ Yes __ No

If No:

Country of Origin_____

Parent/Guardian Information

Mother: _____ _____ _____ __ Yes __ No

Last Name First Name Address/City/Zip Code Custody of Student?

_____ _____ _____

Home Phone Cell Phone Email Address

Father: _____ _____ _____ __ Yes __ No

Last Name First Name Address/City/Zip Code Custody of Student?

_____ _____ _____

Home Phone Cell Phone Email Address

Step Parent: _____ _____ _____ __ Yes __ No

Last Name First Name Address/City/Zip Code Custody of Student?

_____ _____ _____

Home Phone Cell Phone Email Address

Guardian: _____ _____ _____ __ Yes __ No

Last Name First Name Address/City/Zip Code Custody of Student?

_____ _____ _____

Home Phone Cell Phone Email Address

SunBridge Schools 2020-2021 Enrollment Form

1850 Airport Hwy Toledo OH, 43609

School History (Last School Attended)

_____ _____

Previous School Name 19-20 Grade

_____

Address/City/State/Zip

Family Information

Name of school-age natural and step-brother and sisters now living at home

Last Name	First Name	MI	DOB

_____ _____

Emergency Contact Phone Number

_____ _____

Family Dentist Phone Number

_____ _____

Family Doctor Phone Number

_____

Medical History, allergies, medications, physical Impairments or other conditions

_____

Preferred Hospital Name

Do you give consent for the administration of emergency treatment, if emergency contact person cannot be reached? ___ Yes ____ No

Parent Employment

Mother: _____ _____

Employer Name Employer Phone Number

_____

Employer Address/City/State/Zip

Father: _____ _____

Employer Name Employer Phone Number

_____

Step Parent: _____ _____

Employer Name Employer Phone Number

_____

Employer Address/City/State/Zip

Guardian: _____ _____

Employer Name Employer Phone Number

_____

Employer Address/City/State/Zip

Pick Up Permission

Names of any people outside of parent/guardian who can pick your student up from school

First Name	Last Name	Phone Number

Special Services

Is your child receiving any special services?

IEP ___ Yes ___ No 504 Plan ___ Yes ___ No Other ___Yes ___ No

If Yes is this IEP for

___*Academics*___ *Behavior* Please provide copies of any ETR, IEP, Service Plan, 504, etc.

SunBridge SCHOOLS

School Health Examination Record – Health & Immunization History

PART I - TO BE COMPLETED BY PARENT / GUARDIAN- ALL STUDENTS

Child's Name _____
(Print) Last First Middle

A. ALLERGIES – PLEASE LIST AND DESCRIBE ALLERGIES OR REACTIONS TO:

Medicines/Drugs: _____

Foods/Plants/Animals/Other: _____

Recommended treatment is allergy is severe: _____

B. INJURIES AND ILLNESSES – PLEASE LIST ANY SEVERE INJURIES OR ILLNESSES:

Injury / Illness	Age of Child	Check if hospitalized

C. ADDITIONAL INFORMATION:

What medications are given daily? _____

_____

What medications are given frequently, not daily? _____

_____

This child is usually: ☐ very active ☐ normally active ☐ rather inactive

Does any relative or anyone in the home have tuberculosis, diabetes or other serious illness? _____

Is there anything about your child that the school/teacher needs to know to understand him/her better? _____

_____

D. OTHER PERTINENT MEDICAL INFORMATION:

_____

_____

_____

_____

E. SIGNATURE OF PARENT/GUARDIAN:

_____ _____
Signature of Parent/Guardian *Date Signed*

SunBridge SCHOOLS

School Health Examination Record – Health & Immunization History

PART II – TO BE COMPLETED BY PHYSICIAN PRIOR TO SCHOOL ADMISSION- NEW STUDENTS ONLY

Print Student's Last Name _____ First _____ M.I. _____ Date of Birth _____

F. IMMUNIZATION RECORD: Minimum requirements are listed for each vaccine. Those marked with an (*) are required by the Ohio Department of Health; all others are recommended by the Centers for Disease Control and Prevention.

RECOMMENDED IMMUNIZATION (ENTER MONTH, DAY AND YEAR)					
VACCINES	**DOSE 1**	**DOSE 2**	**DOSE 3**	**DOSE 4**	**DOSE 5**
Diphtheria (DTaP), Tetanus (DT/Tdap/Td), Pertussis*					
DTap (7th – 9th grade only) *					
Hepatitis B (Hep B) *					
Measles, Mumps, Rubella (MMR) *					
Polio (IPV or OPV) *					
Varicella (Chicken Pox) * [2 doses K-2; 1 dose 3 – 6]					
Influenza					
Pneumococcal Conjugate (PCV)					
Meningococcal					
Hepatitis A					
Haemophilus Influenza – type b (HIB, preschool only)					
Human Papillomavirus (Gardasil)					

Recommended Assessments/ Screenings:

Vision: ❍ Yes ❍ No Date: _____ Hearing: ❍ Yes ❍ No Date: _____

Dental: ❍ Yes ❍ No Date: _____ Lead: ❍ Yes ❍ No Date: _____

BMI: ❍ Yes ❍ No Date: _____ Other: ❍ Yes ❍ No Date: _____

I have examined this child and found that he/she is in suitable condition for participation in school.
The child has had the age appropriate immunizations as recommended by the Ohio Department of Health.
My office has entered the child's immunization record as noted above or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons:

_____

_____

List any limitations or health conditions for this child (including allergies, daily medication and dietary restrictions):

_____

_____

_____

G. SIGNATURE OF PHYSICIAN/PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE:

_____ Date of Examination _____

Printed Name _____

Office Address _____

City/State/Zip _____ Office Phone: _____

EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name: _____ Grade: _____
Address: _____ Phone Number: _____

"Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached."

Residential Parent/Guardian

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

Other: _____ (Relationship) _____ Daytime Phone: _____

Relative/Child Care Provider

Name: _____ Daytime Phone: _____
Address: _____ Daytime Phone: _____

Name: _____ Daytime Phone: _____
Address: _____ Daytime Phone: _____

Medical Care Providers (*MUST BE COMPLETED*)

Doctor: _____ Phone Number: _____

Dentist: _____ Phone Number: _____

Medical Specialist: _____ Phone Number: _____

Preferred Hospital: _____ Phone Number: _____ ER Phone Number: _____

Please Complete *Either* Part 1 or Part 2 Below:

Part 1: CONSENT TO TREAT

I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS AND LOCAL HOSPITAL TO BE CALLED IN THE EVENT REASONABLE ATTEMPTS TO CONTACT ME HAVE BEEN UNSUCCESSFUL. I HEREBY GIVE MY CONSENT FOR (1) THE ADMINISTRATION OF ANY TREATMENT DEEMED NECESSARY BY THE ABOVE NAMED DOCTOR, OR IN THE EVENT THE DESIGNATED PREFERRED PRACTITIONER IS NOT AVAILABLE, BY OTHER LICENSED PHYSICIAN OR DENTIST; AND (2) THE TRANSFER OF THE CHILD TO ANY HOSPITAL REASONABLY ACCESSIBLE. THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS OR DENTISTS, CONCURRING IN THE NECESSITY FOR SUCH SURGERY, ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY. ***FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES (all allergies including food, medication, environment), MEDICATIONS BEING TAKEN, AND ANY OTHER PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED INCLUDE:***

_____

_____

Parent/Guardian Signature: _____ Date: _____
Address: _____ Daytime Phone: _____

Part 2: REFUSAL TO 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 THE FOLLOWING ACTION:*

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____
Address: _____ Daytime Phone: _____

SunBridge SCHOOLS

MEDIA RELEASE PERMISSION

From time to time we take pictures and video record students during school activities. We would like your permission to use these pictures/videos on our website, in our newsletters, or on our bulletin boards. We will never provide any specific information regarding your child. We also will never sell these pictures or videos; we will use them solely for SunBridge Schools Purposes.

MOVIE PERMISSION

At times throughout the school year, we will be **using movies** in class to supplement lessons or as a reward for good behavior. These movies have the possibility of having a rating of G or PG (parental guidance). District regulations require teachers to have parental permission to show any movies rated over G in class. By signing this permission slip, you are allowing your child to watch a G or PG rated movie in class.

COMPUTER NETWORK PERMISSION SLIP

I understand that my child will have access to and will be using the SunBridge Schools Network, e-mail, and other school-supported media. I also understand that the use of the SunBridge Schools Computer Network is used for state mandated testing. ******Please note: This signed permission slip must be on file at school in order for your child to use the network for the 2020-2021 school year.***

_____

Child's Name (Please Print)

_____

Parent/Guardian's Name (Please Print)

_____

Parent/Guardian's Signature Date

YES, I give permission for my student for the following items:

☐ Pictures ☐ Videos ☐ Movies ☐ Computer Network

NO, I do not give permission for my student for the following items:

☐ Pictures ☐ Videos ☐ Movies ☐ Computer Network

(I allow Computer Network use for testing purposes only).

HOUSEHOLD INFORMATION SURVEY

SunBridge Schools is participating in the Community Eligibility Option (CEO) provision under the National School Lunch Program. Under CEO, all children in the school will receive a breakfast/lunch at no charge regardless of completion of this form. However, to determine eligibility for various additional state and federal program benefits that your child(ren)'s school may qualify for, please complete, sign and return this application to your student's building if your income falls within or below the guidelines listed in the following chart.

INCOME ELIGIBILITY GUIDELINES

Effective from July 1, 2019 to June 30, 2020

HOUSEHOLD SIZE	FEDERAL POVERTY GUIDELINES		REDUCED PRICE MEALS - 185 %						FREE MEALS - 130 %				
	ANNUAL		ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY		ANNUAL	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
48 CONTIGUOUS STATES, DISTRICT OF COLUMBIA, GUAM, AND TERRITORIES													
1	12,490		23,107	1,926	963	889	445		16,237	1,354	677	625	313
2	16,910		31,284	2,607	1,304	1,204	602		21,983	1,832	916	846	423
3	21,330		39,461	3,289	1,645	1,518	759		27,729	2,311	1,156	1,067	534
4	25,750		47,638	3,970	1,985	1,833	917		33,475	2,790	1,395	1,288	644
5	30,170		55,815	4,652	2,326	2,147	1,074		39,221	3,269	1,635	1,509	755
6	34,590		63,992	5,333	2,667	2,462	1,231		44,967	3,748	1,874	1,730	865
7	39,010		72,169	6,015	3,008	2,776	1,388		50,713	4,227	2,114	1,951	976
8	43,430		80,346	6,696	3,348	3,091	1,546		56,459	4,705	2,353	2,172	1,086
For each add'l family member, add	4,420		8,177	682	341	316	158		5,746	479	240	221	111

If any member of your household receives Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) or Ohio Works First (OWF) benefits, provide the name and 10-digit case number for the person who receives the benefits then proceed to Section 4. If no one receives these benefits, start with Section 1.

Name: Case Number:

Child's Name: _____

INSTRUCTIONS: Complete survey and return to your child's school

These selections must be completed by the Head of Household or Designee

1. **SIZE OF FAMILY** - Indicate the total number of individuals living in your household, including all adults and children:_____
2. **STUDENT INFORMATION** - Complete for each student Pre-K through 12th grade

Last Name	First Name	Birth Date MM-DD-YY	School	Identify H if Homeless M if Migrant R if Runaway F if Foster
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

If you need additional lines, attach a second sheet to this survey or attach a copy of this survey clearly marked as Page 2

3. **TOTAL MONTHLY HOUSEHOLD INCOME** – Report Income for all members of household excluding Foster Children. If you have reported a case number above, you do not need to fill in this section. Simply sign and date this form.

Type of Income	Income	Circle if No Income
1. Gross Monthly Earnings: Wages, Salary, Commissions	$	None
2. Monthly Welfare Payments, Child Support, Alimony	$	None
3. Monthly Payments from Pensions, Retirement, Social Security	$	None
4. Monthly Dividends or Interest on Savings	$	None
5. Monthly Worker's Compensation, Unemployment, Strike Benefit	$	None
6. Other Monthly Income (SSI, VA, Disability, Farm, other)	$	None
Total Monthly Household Income (Add lines 1-6)	$	

4. **SIGNATURE** - If Income Section is completed, the adult signing the form must also list the last four (4) digits of his or her Social Security Number or check the "I do not have a Social Security Number" box below.

I certify (promise) that all information on this application is true and that all income is reported. I understand the school will be eligible for certain federal and/or state funds based on the information I give. I understand that the school officials may verify (check) the information. I understand that if I purposely give false information, my child may lose benefits and I may be prosecuted.

Sign Here: X_____ Print Name:_____

Date_____

Last Four (4) Digits of Adult Social Security Number: XXX-XX-_____ ☐ I do not have a Social Security Number

Address City Zip Code

Home Phone	Work Phone	Email Address
		By providing your email address, you may be contact via email by the district

For Office Use Only:

Circle One

QUALIFIES DOES NOT QUALIFY

Transportation Request Form

Student's Name: _____ Date of Birth: _____ Date: _____

Address: _____

Contact Phone: _____

Morning Transportation Address if not the same as above:

_____

_____

Afternoon Transportation Address if not the same as above:

_____

_____

Grade: _____ Previous Bus (if on one): _____

Building: _____

Emergency Contacts:

Name: _____

Phone: _____

Name: _____

Phone: _____

Medical Concerns: _____

Notes: _____

_____

_____

_____ (Initials) I have read & reviewed all bus safety procedures with my child and understand that my child may be suspended from the bus if they do not follow safety rules & procedures that are in place.

_____(Initials) I understand that, if my child is suspended from the bus, it is my responsibility to arrange transportation and ensure that (s)he is in school on time.

_____ (Initials) I give permission for my child to walk home from the bus stop without an adult present. This includes permission to walk home form the bus stop & waiting at the bus stop unsupervised.

_____ (Initials) I understand that SunBridge Schools are not responsible for my child while (s)he is not in their care.

Parent Guardian Signature: _____ Date: _____

Transportation Use Only

Date Received: _____ Start Date: _____ Bus Number: _____

Transportation Request Form

The bus driver/aide is responsible for the safety of all students on the bus. Additionally, the Transportation Director, Mrs. Vikki Colbert, is available when a situation is beyond the control of the bus driver/aide. Students who have the opportunity to ride school buses may do so as long as they display behavior that is reasonable and safe. Some bus rides may be 2 hours long because of traffic and/or trains.

Bus Behavior Rules

(According to OAC 3301-83-08)

1. Students are to remain seated at all times while the bus is running. No jumping seats, standing up, or walking the aisles. Bus aisles are to be kept clear at all times.
2. Disruptive and aggressive behavior will not be permitted. Students should keep their hands to themselves at all times.
3. Students are not allowed to touch any of the red exit handles (except in case of emergency) on windows or stick their arms, hands or head out of windows.
4. Yelling, screaming, and inappropriate language is not permitted on the bus. All students must be silent at railroad crossings.
5. Students are to be at their bus stop 5 minutes before the scheduled pick up time. Students are to remain a safe distance (6 feet) from the bus until the bus has stopped. Playing in the road is not acceptable.
6. Students must refrain from eating and drinking on the bus, except for documented medical reasons.

A copy of these rules is available in the student handbook or in the SunBridge Schools Transportation Office.

ONLY NEW STUDENTS TO SUNBRIDGE NEED TO FILL THIS FORM OUT. THANK YOU!

SunBridge SCHOOLS

ACADEMIC CHILD HISTORY FORM

Instructions to parents: Please complete this form to the best of your knowledge and return it to SunBridge Schools promptly. If a question does not apply to your child, place **N/A** in the blank. If you need more space to answer a particular question, please attach a separate sheet. Thank You!

PARENT INFORMATION

Does the student live with both parents? YES / NO (Please circle)

Mother's Employer: _____ **Phone:** _____ **Ext.**_____
Address: _____
City: _____ **State:** _____ **Zip:** _____

Father's Employer: _____ **Phone:** _____ **Ext.**_____
Address: _____
City: _____ **State:** _____ **Zip:** _____

MEDICAL HISTORY

Most Recent Medical Examination: _____
Doctor /Pediatrician: _____ **Phone:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

Describe any surgery and resulting recommendations: _____
_____

Any history of the following: ***(Please check all that apply)***

- € Glaucoma
- € High Blood Pressure
- € Learning Disabilities
- € Developmental Delays
- € ADD or ADHD
- € Seizure Disorders
- € Cerebral Palsy
- € Autism
- € Other:_____

List illnesses, bad falls, head injuries, high fevers, etc. Complications and Ages:

MEDICAL HISTORY CONTINUED

Does your child currently receive:

Occupational therapy services? YES / NO
If So By Whom? _____
Date Service Began: _____

Physical therapy services? YES / NO
If So By Whom? _____
Date Service Began: _____

Speech therapy services? YES / NO
If So By Whom? _____
Date Service Began: _____

Other therapy services? YES / NO
If So By Whom? _____
Date Service Began: _____

WOULD YOU LIKE TO SET UP SERVICE FOR YOUR CHILD? YES /NO

NUTRITIONAL INFORMATION

Current Diet:

- € Excellent
- € Good
- € Fair
- € Poor

Does your child crave sweets?

- € Yes
- € No

Is your child:

- € Moderately active
- € Extremely active

Are there periods of: High Energy: YES/ NO **What time:**_____
Low Energy: YES/NO **What time:**_____

Allergies to foods/medications? _____

_____

Special Diets? _____

BIRTH/DEVELOPMENTAL HISTORY

Full Term Pregnancy? YES / NO

Any complications before, during, or immediately following birth? _____

_____

Normal Pregnancy? YES / NO

Birth Weight: _____

Was the child adopted? Yes _____ No _____ If Yes, at what age? _____ From where? _____

Were there any complications at birth that might impact on learning? _____

_____

Does the child have any physical defects? _____ Yes _____ No

If Yes, describe_____

_____

Was the child's motor development: Average? _____ Fast? _____ Slow? _____

Was the child's speech development: Average? _____ Fast? _____ Slow? _____

VISION HISTORY

Previous Eye Examination

Doctor's Name: _____ **Date:** _____

Reason for Exam: _____ **Results:** _____

Were glasses prescribed? YES / NO

PRESENT SITUATION

FAMILY HISTORY:

Father's Age: _____ **Present Occupation:** _____

Education (highest level): _____

Did he have any developmental delays, speech problems, or special learning problems?

Yes / No **If Yes, please describe:** _____

_____

Mother's Age: _____ **Present Occupation:** _____

Education (highest level): _____

Did she have any developmental delays, speech problems, or special learning problems?

Yes / No **If Yes, please describe:** _____

_____

Are the parents: Divorced? Separated? If divorced, what are the custody arrangements?
(Please attach a copy of the custody papers):_____

Does the child see the non-custodial parent? Yes /No If Yes, how often? _____

Comments:

Names of Siblings	Full or half Sibling?	Age	Sex	Developmental/ Speech Problems?	Special Education?

Other persons living in the home:

Name	Age	Relation to Child

Does your child report any of the following?

- € Headaches?
- € Blurred Vision?
- € Double Vision?
- € Eyes "hurt or tired"?
- € Tilting head when Reading
- € Confuses letters with words
- € Reverses letters and words
- € Skips, rereads, or omits words
- € Reads slowly
- € Writes or prints poorly
- € Tires easily
- € Short attention span
- € Poor motor coordination
- € Difficulty catching a ball

BEHAVIOR AND SOCIAL HISTORY

Please check if any of the following traits are characteristic of your child:

_ Nervous? _ Destructive?
_ Well-behaved? _ Easily discouraged?
_ Clumsy? _ Easily excitable?
_ Impulsive? _ Selfish?
_ Stubborn? _ Jealous?
_ Shy? _ Poor eater?
_ Show-Off? _ Picky eater?
_ Rude? _ Slow to respond?
_ Distractible? _ Quick to respond?

Please check any of the following behaviors that your child exhibits:

_ Wet the bed? _ Set fires?
_ Have temper tantrums? _ Suck his/her thumb?
_ Refuse to obey? _ Steal?
_ Run away when called? _ Lie?
_ Whine frequently? _ Fight with others?
_ Hurt pets? _ Prefer older children?
_ Drool? _ Prefer younger children?
_ Hit, kick or bite others? _ Eat inedible objects?
_ Bang his/her head? _ Have blank spells?

_ Repeat the same act for an undue length of time? Number of times per week? ___ Per month? ___
_ Have toilet accidents during the daytime?
_ Walk in his/her sleep?
_ Have nightmares frequently?
Number of times per week? ___ Per month? ___

How long will the child pay attention to preferred activities (TV, games, etc.)?
_____ 20 min. _____ 10 min. _____ 5 min. _____ Less _____More how Long? _____

How long will the child pay attention to non-preferred activities?
_____ 20 min. _____ 10 min. _____ 5 min. _____ Less _____More how Long? _____

What are non-preferred activities? _____

Has the child had any traumatic or unusual experiences, such as accidents, severe illness, or frightening situations? _____ Yes _____ No If Yes, describe: _____
_____
_____

Does the child have any strong fears or dislikes? _____ Yes _____ No If Yes, describe: _____
_____

Are there significant conflicts (e.g., marital, child/parent, child/siblings) in the home? ____ Yes ____ No
If Yes, describe: _____
_____

What are your child's strengths? _____
_____
What are your child's weaknesses? _____
_____

Which hand does the child prefer? Right _____ Left _____ Switches _____ Age established? _____
Are there languages other than English spoken in the home? ____ Yes _____ No If Yes, what language(s)? _____

Does the child speak or understand other languages? _____ Yes No ____ If Yes, what languages?
_____
Who can help the child with home learning activities? _____
_____

SCHOOL

Current Grade: _____ **Teacher's name:** _____
Is the child frequently absent? _____ Yes _____ No If Yes, why? _____
_____
_____

Has the child ever failed a grade, been held back, or skipped a grade? ____ Yes ____ No
If Yes, when? _____

Name of Person Completing this Form: _____
Relationship to Child: _____ **Date:** _____

Ohio | Department of Education

Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

Student Name: *(First Name and Last Name)*	**Student Date of Birth:** *(mm/dd/yyyy)*

Communication Preferences Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.	1. In what language(s) would your family prefer to communicate with the school? _____
Language Background Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.	2. What language did your child learn first? _____ 3. What language does your child use the most at home? _____ 4. What languages are used in your home? _____
Prior Education Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.	5. In what country was your child born? _____ 6. Has your child ever received formal education outside of the United States? ☐ Yes ☐ No If yes, how many years/months? _____ If yes, what was the language of instruction? _____ 7. Has your child attended school in the United States? ☐ Yes ☐ No If yes, when did your child first attend a school in the United States? _____ / _____ / _____ Month Day Year
Additional Information Please share additional information to help us understand your child's language experiences and educational background.	

Parent/Guardian First Name: _____ Parent/Guardian Last Name: _____

Parent/Guardian Signature: _____ Today's Date: *(mm/dd/yyyy)* _____

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: https://www2.ed.gov/about/offices/list/ocr/ellresources.html

Ohio School Report Cards

F

School Grade

SunBridge Schools

Districts and schools report information for the Ohio School Report Cards on specific marks of performance, called measures, within broad categories called components. They receive grades for up to ten measures and six components.

Achievement

F

Component Grade

The Achievement Component represents whether student performance on state tests met established thresholds and how well students performed on tests overall. A new indicator measures chronic absenteeism.

Performance Index

43.7% **F**

Indicators Met

0.0% **F**

Progress

D

Component Grade

The Progress component looks closely at the growth that all students are making based on their past performances.

Value-Added

Overall	**F**
Gifted	**NR**
Lowest 20% in Achievement	**F**
Students with Disabilities	**D**

Gap Closing

F

Component Grade

The Gap Closing component shows how well schools are meeting the performance expectations for our most vulnerable students in English language arts, math, graduation and English language proficiency.

Annual Measurable Objectives

0.0% **F**

Graduation Rate

NR

Component Grade

The Graduation Rate component looks at the percent of students who are successfully finishing high school with a diploma in four or five years.

Graduation Rates

This school is not evaluated for graduation rate because there are not enough students in the graduating class.

Improving At-Risk K-3 Readers

D

Component Grade

This component looks at how successful the school is at improving at-risk K-3 readers.

Improving At-Risk K-3 Readers

21.2% **D**

Prepared for Success

NR

Component Grade

Whether training in a technical field or preparing for work or college, the Prepared for Success component looks at how well prepared Ohio's students are for all future opportunities.