Technological College Preparatory World Academy
6000 Ridge Avenue★Cincinnati, OH 45213 ★Tel: 513.531.9500 ★ Fax: 513.531.2406

August 2019 – June 2020 (SY 2019-2020)

Thank you for contacting the office at **Technological College Preparatory (T.C.P.) World Academy.**

Enclosed you will find the **Admission Application Packet** that you requested. Please complete the application in its entirety and return it to the school office along with the necessary documents, which are listed below, for faster processing. All verification documents are required at the time of application submission.

Please be sure to include a copy of the following documents when the **completed Application for Admission** is returned:

- ☐ **Birth Certificate**
- ☐ **Social Security Card**
- ☐ **Immunization Record**
- ☐ **Proof of Residency** (example: *(phone bill, utility bill, lease/rental agreement, etc.)*
- ☐ **Proof of Income** (If you are applying for the Free/Reduced Priced Meals Program)
- ☐ **Most recent Report Card (1^{st} – 6^{th} Grades)**
- ☐ **Standardized Testing Reports**
- ☐ **Custody Documents** (if applicable)

Completion of the process **DOES NOT ENSURE** that your child has been accepted and will attend *T.C.P. World Academy.* Once classes are full, your child will be on the waiting list. Parents of potential students will be called when a space becomes available in the appropriate grade for your child; therefore it is Important that your contact information is current.

Should you have any questions or need additional information, feel free to contact the office any week day between the hours of 8:30 a.m. and 4:30 p.m.

Thank you for your interest in T.C.P. World Academy.

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Enrollment – Proving Residency

Proof of residency shall be required for all newly enrolled students and for all change of address requests. Residency shall be established by providing an original or copy of one (1) item from List A OR one (1) item from List B.

List A	List B
(1) Homeowner Deed (A printout from the auditor's website may be provided instead of a deed.)	**(1) Homeowner or Renter Insurance Statement**(Must be dated within the last 12 months)
(2) Property Tax Statement (Must be dated within the previous year and be addressed to the parent at the residence.)	**(2) Gas/Electric/Water Statement**(Must be dated within the last 30 days)
	(3) Federal or state tax returns (Must be dated within the last 12 months)
(3) Mortgage Statement (Must be dated within previous 60 days and be addressed to the parent at the residence.)	**(4) Any piece of mail from the federal, state, or local government (Hamilton Cty Jobs and Family Services, Social Security, Child Support Enforcement Agency, etc.)**(Must be dated within the last 30 days)
(4) Rental Agreement (Must be signed by both landlord and tenant and include the landlord's contact information.)	
(5) Construction Contract (Must include: (1) a sworn statement describing the location of the house to be built and stating the parent's intention to reside there upon completion; and (2) a statement from the builder confirming that a new house is being built for the parent and that the house is at the location indicated in the parent's sworn statement.)	**NOTE: CPS accepts Parent Residency and Property Owner Affidavits with the required proof of residency documents.** **CPS does not accept notarized statements as proof of residency.**

If you are living with a relative and do not have any of the above documents in your own name, or have any additional questions, please contact our office at (513) 531-9500.

1-30-2013

☆ CHARTER/COMMUNITY SCHOOL ☆

STUDENT INFORMATION

School Name T. C. P. World Academy

School Year 2019-2020 **Today's Date** ❶

School Code 985 ___/___/___

School Use Only

Enroll on Date ___/___/_____ From School _____

Withdraw on Date ___/___/_____ To School _____

Modify Student Data as of ___/___/_____

Submitted by (print)_____ Signed _____

Student

Please provide legal names.

Last Name _____

First Name _____

Middle Name _____

Entering Grade Level _____

Gender (Check One) ☐Male ☐Female

Resident Address _____

Apartment _____

City _____

State _____

Zip Code _____

Phone Number _____ Unl: ☐ No ☐ Yes

Birthdate(mm/dd/yyyy) ____/____/_____

Birth Document Source _____

Social Security Number ____-____-____ (if issued)

Race/Ethnic Code (Check One) ☐Black ☐White ☐Hispanic ☐Asian/Pacific Islander ☐Multi-Racial ☐Native American

Birthplace (City,St) _____

Birthplace (Country) _____

Nationality _____

Nickname (If Any) _____

Parent/Guardian _____

(CPS Use) Student ID ☐☐☐☐☐☐☐☐☐

Parent/Guardian Resident District if not CPS

_____

Emergency Contacts

Name _____

Relation _____

Phone _____

Alt/Cell Ph _____

Name _____

Relation _____

Phone _____

Alt/Cell Ph _____

Home Language: What was this student's first language? (i. e. native language) _____

What language does this student most frequently speak? _____

What language is most often spoken by adults at home? _____

Withdrawal Authorization

Parent signature authorizes the Student Information Systems Department, Cincinnati Public Schools to withdraw this student from their current school of enrollment. I understand that this authorization will remove my child from the current school of enrollment and/or waiting list. There is no guarantee that my child will be re-enrolled if this current school is a magnet school and the charter school is no longer desired.

Parent/Guardian Signature _____ Date _____

CHARTER/COMMUNITY SCHOOL
STUDENT REGISTRATION INFORMATION

Today's Date ❷ ___ / ___ / ___

Use additional pages as necessary. Student Name ______________________

☐Mother ☐Father ☐Guardian ☐Stepparent ☐@Foster parent ☐Grandparent ☐Surrogate Parent ☐Other

Last Name ______________________ Deceased? ☐ No ☐ Yes
First Name ______________________ District of Residence ______
Marital Status ☐ Married ☐ Unmarried ☐ Widowed District of Primary Residence ______
☐ Separated ☐ Divorced Residents With Student? ☐ No ☐ Yes

If you check Divorce or Separated, we require current legal documentation related to the children.

(*)Address ______________________
City ______________________ Custodial Parent? ☐ No ☐ Yes
State ______________________ Legal Guardian? ☐ No ☐ Yes
Zip Code ______________________ Grandparent POA? (see #) ☐ No ☐ Yes
Phone Number ____________ Unl: ☐ No ☐ Yes Caregiver Authorization? ☐ No ☐ Yes
Alt/Cell Phone ____________ Is the parent/guardian an active member of the military? ☐ No ☐ Yes
Email Address ______________________
Work Phone ______________________ Mail if not Custodial Parent? ☐ No ☐ Yes

☐Mother ☐Father ☐Guardian ☐Stepparent ☐@Foster parent ☐Grandparent ☐Surrogate Parent ☐Other

Last Name ______________________ Deceased? ☐ No ☐ Yes
First Name ______________________ District of Residence ______
Marital Status ☐ Married ☐ Unmarried ☐ Widowed District of Primary Residence ______
☐ Separated ☐ Divorced Resides With Student? ☐ No ☐ Yes

If you check Divorce or Separated, we require current legal documentation related to the children.

(*)Address ______________________
City ______________________ Custodial Parent? ☐ No ☐ Yes
State ______________________ Legal Guardian? ☐ No ☐ Yes
Zip Code ______________________ Grandparent POA? (see #) ☐ No ☐ Yes
Phone Number ____________ Unl: ☐ No ☐ Yes Caregiver Authorization? ☐ No ☐ Yes
Alt/Cell Phone ____________ Is the parent/guardian an active member of the military? ☐ No ☐ Yes
Email Address ______________________
Work Phone ______________________ Mail if not Custodial Parent? ☐ No ☐ Yes

☐Mother ☐Father ☐Guardian ☐Stepparent ☐@Foster parent ☐Grandparent ☐Surrogate Parent ☐Other

Last Name ______________________ Deceased? ☐ No ☐ Yes
First Name ______________________ District of Residence ______
Marital Status ☐ Married ☐ Unmarried ☐ Widowed District of Primary Residence ______
☐ Separated ☐ Divorced Resides With Student? ☐ No ☐ Yes

If you check Divorce or Separated, we require current legal documentation related to the children.

(*)Address ______________________
City ______________________ Custodial Parent? ☐ No ☐ Yes
State ______________________ Legal Guardian? ☐ No ☐ Yes
Zip Code ______________________ Grandparent POA? (see #) ☐ No ☐ Yes
Phone Number ____________ Unl: ☐ No ☐ Yes Caregiver Authorization? ☐ No ☐ Yes
Alt/Cell Phone ____________ Is the parent/guardian an active member of the military? ☐ No ☐ Yes
Email Address ______________________
Work Phone ______________________ Mail if not Custodial Parent? ☐ No ☐ Yes

(*) If different from student's address
[#] If parent is not custodial, include copy of Grandparent Power of Attorney and Caregiver Authorization.
@ **If foster parent,** obtain copy of court order showing district of responsibility. Retain in cumulative file.

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Student Residency Questionnaire

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency informati0on help determine the service the student may be eligible to receive.

Name of the School _____

Name of Student _____ Sex: ☐ Male ☐ Female

Birth Date _____ Age_____ Phone Number _____
Day/Month/Year

Address _____ City _____ Zip Code _____

Is your current address a temporary living arrangement? ☐ Yes ☐ No

Is this temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

Name of person who student resides with _____

Please choose which of the following situations the student currently resides in (*you can choose more than one)*:

☐ House or apartment with parent or guardian
☐ Motel, care, or campsite
☐ Shelter or other temporary housing
☐ With friends or family members
(other than *or in addition to parent/guardian)*

If you are living in shared housing, please check all the following reasons that apply:

☐ Loss of housing
☐ Economic situation
☐ Temporarily waiting for house or apartment
☐ Provide care for a family member
☐ Loss of employment
☐ Parent/Guardian is deployed
☐ Other *(please explain)* _____

Print Name of Parent/Legal Guardian _____

Signature of Parent/Legal Guardian _____

Presenting a false record of falsifying records is an offence under section 37.10, Penal code and enrollment of the child under false documents subject the person to liability for tuition or other cost TEC SEC. 25.002(3)(d).

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AUTHORIZATION FOR STUDENT RELEASE

[TO BE COMPLETED BY RESIDENTIAL PARENT OR GUARDIAN]

(PLEASE PRINT)

Student Name _____ Grade _____ Teacher Name _____

Street Address _____ Building/Apt No./Floor _____

City/State/Zip Code _____ Home Phone ( ) _____

Parent/Guardian Name _____ Day Phone ( ) _____ Alternate ( ) _____ ☐ Mother ☐ Guardian

Parent/Guardian Name _____ Day Phone ( ) _____ Alternate ( ) _____ ☐ Father ☐ Guardian

Please list below other T.C.P. students residing in your household:

Student Name _____ Grade ____ Teacher _____

Student Name _____ Grade ____ Teacher _____

Student Name _____ Grade ____ Teacher _____

Student Name _____ Grade ____ Teacher _____

I authorize the following person(s) to pick up my child/ren from T.C.P. World Academy on occasions when I am unable to do so:

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

This authorization is effective as of (date) _____ and I/we understand that it will remain in effect until I/we otherwise notify the school in writing. **I/we will inform the named authorized person(s) to bring photo identification** in case such is requested by school official(s). I/We agree to call the school office **no later than 3:00 p.m. on the day I am unable to pick up my child/ren).**

Signature of Parent (Mother)/Guardian _____ Date _____

Signature of Parent (Father)/Guardian _____ Date _____

For T.C.P. School Office Use Only

Date Received at T.C.P. _____ Additional Note/Comment _____

_____

_____

StudRls010207

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EMERGENCY MEDICAL AUTHORIZATION FORM

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

[PLEASE PRINT THE REQUESTED INFORMATION]

STUDENT INFORMATION

Student's Name _____ Grade Level_____ Teacher_____

Street Address _____ Apt./Floor #_____

City _____ State_____ Zip Code_____ Home Phone ( ) _____

RESIDENTIAL PARENT OR GUARDIAN INFORMATION

Mother's Name _____ Day Phone ( ) _____ Alternate ( ) _____
First Last

Father's Name _____ Day Phone ( ) _____ Alternate ( ) _____
First Last

Name of Closest Relative _____ Relationship _____
First Last

Day Phone ( ) _____ Alternate Phone ( ) _____

Name of Daycare Provider _____
First Last

Street Address _____ City/State/Zip_____
Apt/Floor

Day Phone ( ) _____ Alternate Phone ( ) _____

STUDENT MEDICAL RECORD **(If your child has a medical condition and is required to receive medication during school hours, please complete the following medical information for our office staff.)**

MEDICAL CONDITION	MEDICATION NAME	START DATE	END DATE	DOSAGE	REACTION/ SIDE EFFECT

PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician Name _____ Telephone ( ) _____

Dentist Name _____ Telephone ( ) _____

Medical Specialist _____ Telephone ( ) _____

Local Hospital _____ Emergency Room Telephone ( ) _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the:

(1) administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the

(2) transfer of my 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, medications being taken, and any physical impairments (in addition to information provided in Student Medical Record Section) to which a physician should be alerted:

_____

_____

Parent/Guardian Signature _____ Date _____

Address _____ City/State/Zip _____

PART II - REFUSAL TO GRANT 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 to take the following action:

_____

_____

Parent/Guardian Signature _____ Date _____

Address _____ City/State/Zip _____

NOTE TO ALL PARENTS AND GUARDIANS: It is very important that the contact information we have on file in the school office is current and accurate, particularly emergency contact information. Therefore, please notify the school office immediately in **writing** of any changes in home address, phone number, your child's medical information or emergency contact information.

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REQUEST for SPECIAL MEALS AND/OR ACCOMMODATIONS
INSTRUCTIONS

1. **School/Agency:** Print the name of the center, school or agency that is providing the form to the parent/guardian.
2. **Site:** Print the name of the site where meals will be served (e.g., child care center, school site community center, etc.)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the participant Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, peanut allergy, etc.)
10. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability. For example: "Allergy to peanuts causes a life-threatening reaction affecting the respiratory system."
11. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
12. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
13. A. **Foods to Be Omitted:** List specific foods that must be omitted. For example, "exclude fluid milk."
    B. **Foods to Be Substituted:** List specific foods to include in the diet. For example, "calcium fortified juice."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. (Examples may include a "sippy" cup, a large handled spoon, wheel-chair accessible furniture, etc.)
15. **Signature of Preparer:** Signature of person completing form.
16. **Printed Name:** Print name of person completing form.
17. **Telephone Number:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name:** Print name of medical authority.
21. **Telephone Number:** Telephone number of medical authority.
22. **Date:** Date medical authority signed form.

DEFINITIONS*:

"A Person with a Disability" is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

"Physical or mentqal impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organsl; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Major life activities" are functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

"Has a record of such and impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

(For additional informatio0n on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973).

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MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. SCHOOL/AGENCY	2. Site	3. Site Telephone Number
T.C.P. WORLD ACADEMY	6000 RIDGE AVENUE - CINCINNATI, OH 45213	
4. Name of Participant		5. AGE OR Date of Birth
6. Name of Parent or Guardian		7. Telephone Number

8. Check One:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to instructions.) CACFP, schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician must sign this form.**

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. CACFP, schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, or nurse practitioner must sign this form.**

☐ Participant does not have a disability, but is requesting a special accommodation for a **fluid milk substitute** that meets the nutrient standards for non-dairy beverages offered as milk substitutes. Food preferences are not an appropriate use of this form. CACFP, schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, nurse practitioner or parent or guardian may sign this form.**

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: *(please describe in detail to ensure proper implementation-use extra pages as needed)*

12. Foods to be omitted and substitutions: *(please list specific foods to be omitted and required substitution; attach a sheet with additional information as needed)*

A. Foods To Be Omitted	B. Foods to be Substituted

13. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

14. Adaptive Equipment:

15. Signature of Preparer	16. Printed Name	17. Telephone Number	18. Date
19. Signature of Medical Authority*	**20. Printed Name**	**21. Telephone Number**	**22. Date**

*** Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

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AUTHORIZATION TO RELEASE INFORMATION

_____ **authorizes the release of the records of**
Parent / Guardian Name

_____ _____ _____ ___/___/____
Student's Last Name **First Name** **Mid. Initial** **Birth date** **Mon/ Day/ Year**

From the Following School/Institution:
Most Recent School _____
Address _____
City, State, Zip Code _____
Telephone No. _____ Fax No. _____
Grade Level _____

The following records may be released. Please check.

- ☐ Transcript of subjects and grades
- ☐ Attendance Record
- ☐ Psychological or Other Individual Test Result
- ☐ 504 Accommodation Plan
- ☐ English Language Proficiency Assessments
- ☐ Special Education Records, Including IEP and MFE and behavior plan
- ☐ Ohio Proficiency Test Results
- ☐ Standardized Test Results
- ☐ Gifted Assessments
- ☐ Health Records

☺ ***Items that cannot be withheld due to non-payment of fees or obligations are state test scores, multifactored evaluation evaluation (MFE), Individual education program (IEP), IEP progress reports and immunization records.***

The records may be released to:

TECHNOLOGICAL COLLEGE PREPARATORY WORLD ACADEMY
6000 RIDGE AVE.
CINCINNATI, OHIO 45213
PH: 513-531-9500 FAX: 513-531-2406

I am authorizing the release of these records for these reasons. Please check one.

☐ I am the subject of the records and 18 years of age or older.

☐ I am the parent, guardian, or custodian of the subject of these records and the subject is under 18 years of age.

_____ _____/_____/_____
Signature Date

Request for Records

To the Registrar:
Please send the above records, if available for this student as soon as possible.
If records are not available, please return our request indicating the following:

☐ No Records Available. Reason(s):
_____

☐ Unable to Send Records. Reason(s):
_____

We would appreciate receiving any additional information that would enable us to better meet the individual needs of the student. Thank you for your prompt cooperation.

Sincerely, _____ _____
School Registrar **Date**