



Technological College Preparatory World Academy

6000 Ridge Avenue ★ Cincinnati, OH 45213 ★ Tel: 513.531.9500 ★ Fax: 513.531.2406

August 2023 – June 2024 (SY 2023-2024)

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**
- Parent Picture I.D.**
- 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 (1st – 6th 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 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 Monday to Friday between the hours of 8:30 a.m. and 4:30 p.m.

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

★ CHARTER/COMMUNITY SCHOOL ★

STUDENT INFORMATION

School Year 2023-2024 Today's Date ①

School Name T. C. P. World Academy

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.

(CPS Use)

Student ID

--	--	--	--	--	--	--	--	--	--

Last Name _____

First Name _____

Middle Name _____

Entering Grade Level _____

Gender (Check One) Male Female

Parent/Guardian Resident District if not CPS

Resident Address _____

Apartment _____

City _____

State _____

Zip Code _____

Phone Number _____ Unl: No Yes

Birthdate(mm/dd/yyyy) ___/___/___

Birth Document Source _____

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

Emergency Contacts

Name _____

Relation _____

Phone _____

Alt/Cell Ph _____

Race/Ethnic Code Black White Hispanic

(Check One) Asian/Pacific Islander Multi-Racial

Native American

Birthplace (City,St) _____

Name _____

Relation _____

Phone _____

Alt/Cell Ph _____

Birthplace (Country) _____

Nationality _____

Nickname (If Any) _____

Parent/Guardian _____

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 **2**
____/____/____

Use additional pages as necessary.

Student Name _____

<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Stepparent <input type="checkbox"/> @Foster parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Surrogate Parent <input type="checkbox"/> Other	
Last Name _____	Deceased? <input type="checkbox"/> No <input type="checkbox"/> Yes
First Name _____	District of Residence _____
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Widowed	District of Primary Residence _____
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Resides With Student? <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If you check Divorce or Separated, we require current legal documentation related to the children.</i>	
(*)Address _____	Custodial Parent? <input type="checkbox"/> No <input type="checkbox"/> Yes
City _____	Legal Guardian? <input type="checkbox"/> No <input type="checkbox"/> Yes
State _____	Grandparent POA? (see #) <input type="checkbox"/> No <input type="checkbox"/> Yes
Zip Code _____	Caregiver Authorization? <input type="checkbox"/> No <input type="checkbox"/> Yes
Phone Number _____ Unl: <input type="checkbox"/> No <input type="checkbox"/> Yes	Is the parent/guardian an active member of the military? <input type="checkbox"/> No <input type="checkbox"/> Yes
Alt/Cell Phone _____	Mail if not Custodial Parent? <input type="checkbox"/> No <input type="checkbox"/> Yes
Email Address _____	
Work Phone _____	

<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Stepparent <input type="checkbox"/> @Foster parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Surrogate Parent <input type="checkbox"/> Other	
Last Name _____	Deceased? <input type="checkbox"/> No <input type="checkbox"/> Yes
First Name _____	District of Residence _____
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Widowed	District of Primary Residence _____
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Resides With Student? <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If you check Divorce or Separated, we require current legal documentation related to the children.</i>	
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State _____	Grandparent POA? (see #) <input type="checkbox"/> No <input type="checkbox"/> Yes
Zip Code _____	Caregiver Authorization? <input type="checkbox"/> No <input type="checkbox"/> Yes
Phone Number _____ Unl: <input type="checkbox"/> No <input type="checkbox"/> Yes	Is the parent/guardian an active member of the military? <input type="checkbox"/> No <input type="checkbox"/> Yes
Alt/Cell Phone _____	Mail if not Custodial Parent? <input type="checkbox"/> No <input type="checkbox"/> Yes
Email Address _____	
Work Phone _____	

<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Stepparent <input type="checkbox"/> @Foster parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Surrogate Parent <input type="checkbox"/> Other	
Last Name _____	Deceased? <input type="checkbox"/> No <input type="checkbox"/> Yes
First Name _____	District of Residence _____
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Widowed	District of Primary Residence _____
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Resides With Student? <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If you check Divorce or Separated, we require current legal documentation related to the children.</i>	
(*)Address _____	Custodial Parent? <input type="checkbox"/> No <input type="checkbox"/> Yes
City _____	Legal Guardian? <input type="checkbox"/> No <input type="checkbox"/> Yes
State _____	Grandparent POA? (see #) <input type="checkbox"/> No <input type="checkbox"/> Yes
Zip Code _____	Caregiver Authorization? <input type="checkbox"/> No <input type="checkbox"/> Yes
Phone Number _____ Unl: <input type="checkbox"/> No <input type="checkbox"/> Yes	Is the parent/guardian an active member of the military? <input type="checkbox"/> No <input type="checkbox"/> Yes
Alt/Cell Phone _____	Mail if not Custodial Parent? <input type="checkbox"/> No <input type="checkbox"/> Yes
Email Address _____	
Work Phone _____	

(*) 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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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 _____



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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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Student Residency Questionnaire

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

Name of the School T.C.P. World Academy

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*):

- | | |
|---|--|
| <input type="checkbox"/> House or apartment with parent or guardian | <input type="checkbox"/> Shelter or other temporary housing |
| <input type="checkbox"/> Motel, care, or campsite | <input type="checkbox"/> With friends or family members
<small>(other than or in addition to parent/guardian)</small> |

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

- | | |
|---|--|
| <input type="checkbox"/> Loss of housing | <input type="checkbox"/> Loss of employment |
| <input type="checkbox"/> Economic situation | <input type="checkbox"/> Parent/Guardian is deployed |
| <input type="checkbox"/> Temporarily waiting for house or apartment | <input type="checkbox"/> Other <small>(please explain)</small> _____ |
| <input type="checkbox"/> Provide care for a family member | |

Print Name of Parent/Legal Guardian _____

Signature of Parent/Legal Guardian _____

Presenting a false record or 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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MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. SCHOOL/AGENCY T.C.P. WORLD ACADEMY		2. Site 6000 RIDGE AVENUE - CINCINNATI, OH 45213		3. Site Telephone Number	
4. Name of Participant				5. AGE OR Date of Birth	
6. Name of Parent or Guardian				7. Telephone Number	
8. Check One:					
<input type="checkbox"/> Participant has a disability or a medical condition and <i>requires</i> 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.					
<input type="checkbox"/> 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.					
<input type="checkbox"/> 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: <i>(please describe in detail to ensure proper implementation-use extra pages as needed)</i>					
12. Foods to be omitted and substitutions: <i>(please list specific foods to be omitted and required substitution; attach a sheet with additional information as needed)</i>					
A. Foods To Be Omitted			B. Foods to be Substituted		
_____			_____		
_____			_____		
_____			_____		
_____			_____		
13. Indicate texture:					
<input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> 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.

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities. If you wish to file a Civil Rights program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.



**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 mental 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 organs; 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 information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973).

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: <i>(First Name and Last Name)</i> _____		Student Date of Birth: <i>(mm/dd/yyyy)</i> _____	
<p>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.</p>		<p>1. In what language(s) would your family prefer to communicate with the school? _____</p>	
<p>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.</p>		<p>2. What language did your child learn first? _____</p> <p>3. What language does your child use the most at home? _____</p> <p>4. What languages are used in your home? _____</p>	
<p>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.</p>		<p>5. In what country was your child born? _____</p> <p>6. Has your child ever received formal education outside of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many years/months? _____ If yes, what was the language of instruction? _____</p> <p>7. Has your child attended school in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when did your child first attend a school in the United States? _____ / _____ / _____ Month Day Year</p>	
<p>Additional Information Please share additional information to help us understand your child's language experiences and educational background.</p>			
Parent/Guardian First Name: _____		Parent/Guardian Last Name: _____	
Parent/Guardian Signature: _____		Today's Date: <i>(mm/dd/yyyy)</i> _____	

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>



*****COMPLETED BY SCHOOL EMPLOYEE*****

1. **Check.** Confirm the following statements related to the administration of Ohio’s language usage survey:
 - The district or school presented the language usage survey, to the extent practicable, in a language and form that the parent or guardian understood.
 - The district or school informed the parent(s) or guardian(s) of the form’s purpose. The language usage survey only is used to understand students’ linguistic experiences and educational background.
 - The district or school reports information from the language usage survey in the appropriate Educational Management Information System (EMIS) records.
 - For students enrolling from other U.S. schools and districts, school officials request previous language survey data and refer to the information when identifying English learners.
 - Results of the language usage survey are kept with the student’s cumulative records and follow the student if he/she transfers to another district or school.

2. **Note.** Record additional information to assist the review of the language usage survey.

3. **Record.** Indicate responses from the language usage survey in the table below. Refer to the [Language Usage Survey Annotations](#) on page 2 for item-specific guidance.

<p>Student’s native language See Language Usage Survey Question 2. Report for <u>all</u> students in EMIS.</p>	_____
<p>Student’s home language See Language Usage Survey Question 3. Report <u>only</u> for English learners in EMIS.</p>	_____
<p>Potential English learner See Language Usage Survey Questions 2-4.</p>	<input type="checkbox"/> Yes. Assess the student’s English proficiency. <input type="checkbox"/> No. Do not assess the student’s English proficiency.
<p>Immigrant student status See Language Usage Survey Questions 5-7. Report for <u>all</u> students in EMIS.</p>	<input type="checkbox"/> Yes, the student is an immigrant child. <input type="checkbox"/> No, the child is not an immigrant child.

4. **Validate.** Complete the information below.

Signature of validating school employee

Date (mm/dd/yyyy)

Ms. Lillie
Printed name of validating school employee

T.C.P. World Academy
Name of school or school district



Technological College Preparatory World Academy

6000 Ridge Avenue Cincinnati, Ohio 45213.

Tel: 513-531-9500 Fax: 513-531-2406

Superintendent, Karen Y. French

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.

<u>List A</u>	<u>List B</u>
(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) Telephone, Cable Bills, Check Stubs, Credit Cards or Bank Statements are NOT ACCEPTABLE as proof of residence.
(3) Mortgage Statement (Must be dated within previous 60 days and be addressed to the parent at the residence.)	(3) Federal or state tax returns (Must be dated within the last 12 months)
(4) Rental Agreement (Must be current, dated and signed by both landlord and tenant and include the landlord's contact information.)	(4) Any piece of mail from the federal, state, or local government (Hamilton City Jobs and Family Services, Social Security, Child Support Enforcement Agency, etc.) (Must be dated within the last 30 days)
(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.



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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.

- | | |
|---|--|
| <input type="checkbox"/> Transcript of subjects and grades | <input type="checkbox"/> Ohio Proficiency Test Results |
| <input type="checkbox"/> Attendance Record | <input type="checkbox"/> Standardized Test Results |
| <input type="checkbox"/> Psychological or Other Individual Test Result | <input type="checkbox"/> Gifted Assessments |
| <input type="checkbox"/> 504 Accommodation Plan | <input type="checkbox"/> Health Records |
| <input type="checkbox"/> English Language Proficiency Assessments | |
| <input type="checkbox"/> Special Education Records, Including IEP and MFE and behavior plan | |

☺ *Items that cannot be withheld due to non-payment of fees or obligations are state test scores, multifactor 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