ESPERANZA CYBER CHARTER SCHOOL
K-12 ENROLLMENT PACKET
PARENT/GUARDIAN MUST COMPLETE THIS FORM AND PROVIDE ALL NECESSARY DOCUMENTS

Student Information - Section 1		***Please fill out the entire form***
☐ Check here if you are a student registering on your own		
Student's First and Last Name	Address: Street /City /State /Zip Code	
Home Phone	Cell Phone	Email
Student lives with: ☐ Both parents at same address ☐ Mother ☐ Father ☐ Step-Parent ☐ Grandparents ☐ Guardian/Other ☐ Alone without and adult ☐ An adult who is not my legal guardian or parent **Student lives in:** ☐ Permanent Housing ☐ With another family member or other person ☐ Hotel / Motel ☐ Other		
Country of Birth If USA include State	When did you move to PA? (month/year)	Home Primary Language
Race: ☐ Hispanic /Latino ☐ White ☐ Asian ☐ African American/Black ☐Native Hawaiian/Other Pacific Islander ☐American Indian /Alaska Native ☐ Multi-racial/Other	Sex assigned at Birth ☐ Male ☐ Female	Gender Identity Response (optional)
Date of last Physical Exam _____ Proof Attached? ☐Yes ☐No	Immunizations Up to Date? ☐Yes ☐No Proof Attached? ☐Yes ☐No	Date of last Dental Exam Proof Attached? ☐Yes ☐No

Household Information - Section 2			
☐ Does not apply, student does not live with parent or legal guardian			
Primary Parent/Guardian First and Last Name		Email	
Address: Street /City /State /Zip Code	Home Phone	Relationship to Student	Preferred Contact Method ☐Phone ☐Text ☐Email
Primary Parent/Guardian Active Military Duty? ☐Yes ☐No	Work Phone	Cellphone	

List of all school age children (ages 5 or above)	Name & Last Name	Date of Birth	Current School	Current Grade

Student Education History – Section 3

Last School Attended: Name	Address/State/Zip	Date Attended (month/year)	Grade last attended

If the school is outside US, do you have records? ☐Yes ☐No If yes, attach	Did your child attend Pre-K or Kindergarten? ☐Yes ☐No	When did the student enter 9th grade for the first time? (month/year)	Can you provide a career portfolio from the prior school? ☐Yes ☐No If yes, attach	Does your child have a 504 Plan? ☐Yes ☐No If yes, attach

Has your child ever received Special Education Services in PA or another state? ☐Yes ☐No If Yes, which state?	Does your child have a current IEP? ☐Yes ☐No If yes, provide the IEP	Does your child have a current evaluation report? ☐Yes ☐No If yes, provide the report	Was your child enrolled in Early Intervention? ☐Yes ☐No

Affirmation Statement - Section 4

I affirm that all information on this application is true and correct and providing false or incomplete information may delay enrollment. By signing below, I am allowing Esperanza Cyber Charter School to enroll my child as a student. I agree I will not withdraw my child from his/her current school until I have been provided an orientation date.

Parent/Guardian Initials: _____

Home Language Survey

(Required)

All newly registering students regardless of race, nationality, or language origin MUST complete this form. Federal law requires that all schools utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, Esperanza Cyber Charter School has the right to ask for the information contained on this and other forms associated with the identification process. The Pennsylvania Department of Education selected the Home Language Survey as the method for the identification.

Student Name and Last Name:		
Is a language other than English spoken at home?		□ Yes □ No Language:
Does your child communicate in a language other than English?		□ Yes □ No Language:
What is the language your child first learned to speak?		
Has the student attended any U.S school in any three years during his/her lifetime?		□Yes □ No If yes, please complete the following:
Name of School	State	Dates Attended
When was your child first enrolled in a U.S school?		Date (mm/dd/yyyy)
When did your child first enter a school in Pennsylvania?		Date (mm/dd/yyyy)
Is your child receiving ELD/ESL/EL services now?		□ Yes □ No
Has your child been removed or promoted from ELD/ESL/EL services?		□ Yes □ No Date (mm/dd/yyyy)
Person completing this form, if other than parent/guardian.		Name: Relationship to Student:
Parent/Guardian Signature		**Date**

The school district/charter school has the responsibility under the federal law to serve students who are English Learners and need English Language instructional services. Given this responsibility, the school district/charter school has the right to ask for the information it needs to identify English Learners. As part of the responsibility to locate and identify ELs, the school district/charter school may administer tests and ask for information about EL students who are enrolled in the school as well as students who are applying.

McKinney-Vento Assistance Act

(Required, Confidential)

Student Name: _____

The McKinney-Vento Homeless Assistance Act (Title X, Part C, of the No Child Left Behind Act) defines "homeless" as "individuals who lack a fixed, regular, and adequate night's residence." This includes children who "temporarily share other people's housing due to loss of housing or financial hardship."

Check the box that applies:

- ☐ Does not apply; the student is not homeless.
- ☐ Living in a shelter, including transitional housing shelters.
- ☐ Living on the streets, abandoned buildings, in cars, trailers, campgrounds, public places, housing not fit for habitation.
- ☐ Living in hotels/motels for lack of suitable housing.
- ☐ Doubled-up; temporarily living with family or friends due to lack of adequate housing or financial conditions.

☐ *Check here if you are a student registering on your own*

***Please fill out this information if you selected one of the last four options in the previous questionnaire:**	
Student's Address:	
Emergency Contact: Relationship to student:	Phone Number:
Parent/Guardian Information	Phone Number:
Address (if different from student):	

Parental Registration Statement

(Required)

Pennsylvania School Code § 13-130-A State in part "Prior to admission to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration, provide a sworn statement or affirmation stating whether pupil was previously or is presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act offense involving weapons, alcohol or drugs or for the willful infliction of injury to another person or for any act of violence committed on school property."

Student Name	Date of Birth:	Grade:

Please complete the following:

I hereby affirm that my child ☐ was ☐ was not previously suspended or expelled from any public or private school of this Commonwealth or any other state for the act or offense involving weapons, alcohol or drugs or for the willful infliction of injury to another person or for any act of violence committed on school property.

I make this statement subject to the penalties of 24 P.S.§ 13-1304-A (b) and 18Pa. C.S. A.§4904, relating to unsworn falsification to authorities, and the facts contain herein are true and correct to the best of my knowledge.

Parent/Guardian Signature	**Date**

If the student has been or is presently suspended or expelled from another school, please complete the following:

Name of school from which the student was suspended or expelled:

Dates of the suspension or expulsion:

Reason for the suspension or expulsion:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Any willful false statement made above shall be a misdemeanor or the third degree. This form shall be maintained as part of student's disciplinary record.

Release Authorization

(Required)

Should it be necessary to send a child home from the Learning Center or a school-sponsored event due to illness, injury, or other emergency, the School needs parent/guardian contact information, and in the event the School is unable to contact the parent/guardian, permission must be provided as to who your child can be released.

Student Name:	Student lives with: □ Mother □ Father □ Guardian □ Other person _____

Mother / Guardian Name: _____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Father/ Guardian Name: _____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Emergency Contact # 1 Name:	Phone Number (home or personal)	Relationship to Student:
Emergency Contact # 2 Name:	Phone Number (home or personal)	Relationship to Student:
Emergency Contact # 3 Name:	Phone Number (home or personal)	Relationship to Student:

My signature authorizes the school to release my child to ANY of the people listed above. I understand that my child will ONLY be released to these individuals and NO exceptions will be made. I understand that the School CANNOT release my child with telephone consent.

Parent/Guardian Signature:	**Date**

Permission to Photograph or Film
(Required)

Esperanza Cyber Charter School (ECCS) is a public school serving the community. There is a great deal of interest in our school and we expect that interest to continue to grow as time goes on. Because our school is unique, we have many visitors, including parents/guardians of prospective students, students, siblings, members of the community, public officials, and the press and media. From time-to-time, ECCS would like to photograph or videotape our students, faculty, and school activities or allow others to do so. We will use photographs, film, and videotape as part of our classroom instruction and to promote the school and its activities. We hope to accommodate requests by visitors to photograph or videotape our students, faculty, and school activities.

The purpose of this form is to receive your permission to photograph or videotape your child while engaged in school activities, and for the school to use photographs, film, or videotape of your child for school-related purposes.

☐ **I grant permission for ECCS to photograph or videotape and use for school-related purposes any photographs, film, or video of my child.**

☐ **I do not grant permission for ECCS to photograph or videotape and use for school-related purposes any photographs, film, or video of my child.**

Student Name	
Parent/Guardian Signature	**Date**

E-rate Family Survey 2020-2021

(Required)

Please complete and return the survey below. Important: Even if your income does not meet these Income Eligibility Guidelines, you must return the survey for the school's survey to be considered a valid measure.

Student's First and Last Name:			
Street Address:	City:	State:	Zip Code:

I. Find your family annual gross income level on the chart below and circle the number of people in your family, including all children.

Income Eligibility Guidelines 20-21 SY							
Household Size (circle one)	Federal Poverty Guidelines	Free Meals			Reduced Meals		
	Annual	Annual Income	Monthly Income	Weekly Income	Annual Income	Monthly Income	Weekly Income
1	$12,760	$16,588	$1,383	$319	$23,606	$1,968	$454
2	$17,240	$22,412	$1,869	$431	$31,894	$2,658	$614
3	$21,720	$28,235	$2,353	$543	$40,182	$3,349	$773
4	$26,200	$34,060	$2,839	$655	$48,470	$4,040	$933
5	$30,680	$39,884	$3,324	$767	$56,758	$4,730	$1,092
6	$35,160	$45,708	$3,809	$879	$65,046	$5,421	$1,251
7	$39,640	$51,532	$4,295	$991	$73,334	$6,112	$1,411
8	$44,120	$57,356	$4,780	$1,103	$81,622	$6,802	$1,570
For each additional family member, add	$4,480	$5,824	$485	$112	+ $8,288	+ $691	+ $160

Is your income equal or less than any of the amounts listed next to the number you circled?	**Yes**	**No**
Is your family eligible for food stamps?	**Yes**	**No**
Is your family receiving Temporary Assistance for Needy Families (TANF)?	**Yes**	**No**
Does your family qualify for medical assistance under Medicaid?	**Yes**	**No**
Is your family receiving Supplementary Security Income (SSI)?	**Yes**	**No**
Does your family receive housing assistance (section 8)?	**Yes**	**No**
Does your family receive home energy assistance (LIHEAP)?	**Yes**	**No**

I. If your answered YES to any one of the preceding questions, please list the school and grade level for each child living in your home.

Student Name	**School**	**Grade**
Parent/Guardian Print Name	**Parent/Guardian Signature**	**Date**

Request for Student Records

(Required)

Date	**Previous School Name**	
Student Name	**Current Grade**	**Date of Birth**

The student listed above has intent to enroll at Esperanza Cyber Charter School. Please forward a copy of his/her student records to us through the following fax or mailing address:

Esperanza Cyber Charter School

Attention: Enrollment

4261 N. 5th Street, Third Floor

Philadelphia, PA 19140

FAX: Attention Enrollment, 215-689-1400

EMAIL: admissions@esperanzacybercs.net

Student records include: current grades, transcripts, report cards, IEP, Evaluation or Re-evaluation, NOREP, 504, and Psychological, psychiatric, or neurological reports.

☐ **I give permission to release my child's school records to Esperanza Cyber Charter School.**

Parent/Guardian Signature	**Date**

Request for Student Health Records

(Required)

Date	**Physician Name and Address**

Student Name	**Current Grade**	**Date of Birth**

As of today the student listed above is interested in attending Esperanza Cyber Charter School. Please forward a copy of his/her health records to us through the following fax or mailing address:

Esperanza Cyber Charter School

Attention: Admissions

4261 N. 5th Street, Third Floor

Philadelphia, PA 19140

FAX: Attention Admissions, 215-689-1400

EMAIL: Admissions@esperanzacybercs.net

Health records include: annual physical exam, immunization records.

☐ **I give permission to release my child's health records to Esperanza Cyber Charter School.**

Parent/Guardian Signature	**Date**

CHARTER SCHOOL STUDENT ENROLLMENT NOTIFICATION FORM

For School Year 2020-2021

Warning: A child enrolled in another public school or a nonpublic or private school cannot, at the same time, enroll in a charter school.

Name of Charter School: Esperanza Cyber Charter School

Address: 4261 N 5th Street

Philadelphia PA 19140

Charter School Contact Person: Liriam Santiago

Telephone: 215-967-9703 Email Address: liriam.santiago@esperanzacybercs.net

I. Student Information:

Last Name: _____ First Name: _____ Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Phone Number: _____

Mailing Address (if different from physical address): _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____

II. School District of Residence and Former School Information

School District Residence: _____

Former school information (other than pre-school):

_____ Public School _____ Charter School _____ Home School _____ Private School

_____ Student not enrolled School Preceding Enrolment in Charter School because:

_____ Entering Kindergarten _____ Re-enrolling, Dropout _____ Other:

Name of Former School: _____

Address of Former School: _____

_____

Previous Grade: _____ Address of Former School: _____

Was your child receiving Special Education services bases on an IEP? _____ Yes _____ No

If yes, do you have the child's Special Education Records (IEP)? _____ Yes _____ No

III. Parent/Guardian Information:

Child lives with: _____ Both Parents _____ Both Parents Alternately _____ Mother Only _____ Father Only

_____ Legal Guardian _____ Adoptive Parents _____ Other Adult: _____

Special Custodial Court Instructions:
(If yes, please provide a copy of court order) Yes _____ No_____

Complete Parent/Guardian Name and Address Information as Aplication

Mother's Name _____

Street _____ City_____ State_____ Zip Code _____

Home Phone _____ Work Phone_____

Father's Name _____

Street _____ City_____ State_____ Zip Code _____

Home Phone _____ Work Phone_____

If the student is not living with parents, please complete this section.

_____ Guardian's Name _____ Adoptive Parent _____ Other Adult
Name_____

Street _____ City_____ State_____ Zip Code _____

Home Phone _____ Work Phone_____

My signature on this form indicates my decision to have my child attend the charter school named on page 1 of this form and signifies my request that appropriate school records be forwarded from the school district to the charter school. My signature also certifies that my child is not, and will not be, enrolled in another public school, a nonpublic school or a private school at the same time he or she is enrolled in this charter school.

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

IV. To be completed by Charter School

Verification of Date of Birth: _____ Birth Certificate _____ Other: _____

Proof of Residency: _____ Mortgage Statement _____ Lease _____ Utility Bill _____ Other: _____

Official Enrollment Date:_____ Anticipated Date of Attendance: _____

Grade Student is Entering: _____

Signature of Charter School Representative _____

PHYSICAL EDUCATION MEDICAL EXEMPTION / PROGRAM MODIFICATION

(complete as needed)
*(*Debe ser completado por el Medico*)*

To the Parent/Guardian: Participation in our Cyber Physical Education Program is required for all students. Modifications are available for students who are unable to participate in all parts of the program. It is your responsibility to contact the school if the student requires a modified program. In cases of temporary restriction, the student is still required to attend his/her regularly scheduled online physical education/health class. This form is to be completed **every school year** by your physician and returned to the school.

Physician: The Pennsylvania Department of Education requires ALL students to participate in a planned program of physical education at EVERY GRADE LEVEL.

STUDENT LAST NAME	STUDENT FIRST NAME	GRADE	BIRTH DATE – MM/DD/YY

PARENT/GUARDIAN NAME	TELEPHONE	DATE ISSUED

COMPLETED BY CARE PROVIDER

Our patient has requested an excuse from the regular physical education program based on the health condition listed below:

Diagnosis:

1. CHECK DEGREE OF ACTIVITY PERMITTED:

2. CHECK ANYTHING WITHIN THAT CATEGORY WHICH IS NOT PERMITTED.

VIGOROUS				MODERATE (CALISTHENICS & GENERAL EXERCISES REQUIRING MODERATE RUNNING AND MUSCULAR EFFORT)				MILD (I.E. WALKING OR MOVEMENT OF ARMS, NECK & TRUNK)			
	WALKING		AEROBICS		WALKING		AEROBICS		WALKING		AEROBICS
	YOGA		ARM EXERCISES		YOGA		ARM EXERCISES		YOGA		ARM EXERCISES
	KICK-BOXING		LEG EXERCISES		KICK-BOXING		LEG EXERCISES		LEG EXERCISES		
	RUNNING				RUNNING						

DATE OF EXAMINATION_____

RESTRICTION REQUESTED FOR _____WEEKS

MODIFICATION REQUESTED FOR _____WEEKS

Comments:

Signature of Care Provider (REQUIRED)	Telephone	Care Provider office stamp (REQUIRED)

REPORT OF PRIVATE DENTAL EXAMINATION

(complete as needed)

School: Esperanza Cyber Charter School	Date Issued:

To the Dentist:

Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (original entry, 3rd and 7th grades). These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian.

Please attach a copy of the student's dental examination or record the data below.

UNDER TREATMENT/ WORK BEGUN	**COMPLETION OF WORK/ NO TREATMENT NECESSARY**
Date Work Begun	Expected Completion Date
Scheduled Follow-up Appointment	
Date of Dental Examination	
Comments / Follow-up Treatment / Special Instructions to School	
Name of Dentist	Telephone
Signature of Dentist	Date Signed
Dentist Address	Fax Number

RETURN THIS FORM TO:

Esperanza Cyber Charter School

Attention: Admissions

4261 N. 5th Street, Third Floor, Philadelphia, PA 19140

Fax 215-689-1400

Email: Admissions@esperanzacybercs.net

MEDICATION INFORMATION

(complete as needed)

The School realizes it may be important for a student's well-being that medicine be taken when attending school-related events or attending at the Learning Center. It is also important that such medicines be approved in writing by a physician. **This form is required for medicines that are self-administered by the student.** The School will not provide nor administer medications. If your child is ill while attending a school-related activity every effort will be made for the child to be sent home accompanied by an individual authorized for release.
NOTE: The Learning Center does not have the capability to provide special storage requirements.

If the child takes medication does he/she need to take it while in attendance at the Learning Center or during a school-sponsored activity? ☐ Yes ☐ No Physician Initials _____
If Yes, Physician authorization is required for EACH medication. Complete the following:

Name of Medication	Condition	Dosage (amount, time)
Date administration of medication begins	Date administration of medication ends	Potential side effects

Is student fully aware of requirements for storage, transport, and administration of the medication?
☐ Yes ☐ No

Describe any conditions that School personnel should be aware of for the student's self-administration of this medicine	

Physician Signature	**Date**

Name of Medication	Condition	Dosage (amount, time)
Date administration of medication begins	Date administration of medication ends	Potential side effects

Is student fully aware of requirements for storage, transport, and administration of the medication?
☐ Yes ☐ No

Describe any conditions that School personnel should be aware of for the student's self-administration of this medicine	

Physician Signature	**Date**

I hereby grant permission for my child to self-administer the above medications according to the physician's written orders and school policy. I attest the information above is accurate and my child understands his/her responsibilities involving the medication listed above.

Parent/Guardian Signature	**Date**

PA MEDICAL ASSISTANCE BILLING PARENTAL CONSENT FORM

(Required for Special Education Student)

Local Education Agencies (LEAs) are eligible to receive federal Medicaid reimbursement for medically necessary services provided to their special education students when the services meet the requirements of the state's Medicaid program and are provided in accordance with the student's IEP.

The Individuals with Disabilities Education Improvement Act of 2004 (IDEA) and the Family Educational Rights and Privacy Act (FERPA) require schools to obtain written parental consent to share the student's education and health-related records, such as IEPs and Evaluation Reports. The School is requesting your permission to share this information with the PA Department of Education, the PA Department of Public Welfare, and a physician or nurse practitioner in order to bill Medical Assistance.

In addition to the Medicaid-covered services your child receives as part of her/her IEP, Medical Assistance will continue to pay for medically necessary, Medicaid-covered services that are provided to your child outside of school.

I understand that

- **If I give permission, I may withdraw it for future services at any time. However, it does not negate an action that has occurred after consent was given before the consent was revoked.**
- **My refusal to give consent will not change the services my child receives under his/her IEP.**
- **Whether I consent or refuse, I will not have to pay for these services.**
- **Upon request, I may receive copies of my child's records that are disclosed as a result of this authorization.**

☐ I give my child's school permission to share my child's education and health related information and bill Medical Assistance.

Print Parent/Guardian Name	**Parent/Guardian Signature**	**Date**

☐ I do not give my child's school permission to share my child's education and health related information and bill Medical Assistance.

Print Parent/Guardian Name	**Parent/Guardian Signature**	**Date**
Student Full Name		Date of Birth
IEP Meeting Date	Anticipated Duration of Services	

PHYSICAL EXAMINATION ANNUAL SCREENING

Student Name	**Last**	**First**	**M.I.**	**Student ID#**
Age	**Date of Birth**	**Gender**	**Phone Number**	
Student Address	**Number & Street**	**City**	**State**	**Zip Code**

TO THE CARE PROVIDER (Please complete all items)

Pennsylvania law requires that students attending school in the state be immunized and receive periodic medical examinations. Payment for these examinations is the responsibility of the parent/guardian. THESE IMMUNIZATIONS ARE REQUIRED FOR SCHOOL ATTENDANCE. Attach a copy of the student's immunization record, or record the dates below.

VACCINE	ENTER MONTH, DAY, AND YEAR EACH IMMUNIZATION WAS GIVEN DOSES				
Diphtheria and Tetanus* (DTap, DTP, Td or DT)	1. / /	2. / /	3. / /	4. / /	5. / /
Polio, (OPV or IPV)	1. / /	2. / /	3. / /	4. / /	
Hepatitis B	1. / /	2. / /	3. / /		
Measles** - Mumps - Rubella (MMR)	1. / /	2. / /	or Measles Serology: Date _____ Titer __		
Varicella	1. / /	2. / /	Rubella Serology: Date _____ Titer		
			Mumps disease diagnosed by a physician: Date _____		
Other	1. / /	2. / /			

Date of last Tetanus Booster_____ Date of last PPD_____Result_____mm

* One dose must be on or after the fourth (4th) birthday.
** First dose must be on or after the first (1st) birthday and the second dose should be at least one month after the first dose

Does this student have health insurance? ___Yes ___No

Name of Insurance Provider:_____

RECORD THE FOLLOWING

1.	Visual Acuity: Without Glasses: R_____ L_____ With Glasses: R_____ L_____	
2.	Audiometric Screening: R_____ L_____	3. BP_____
4.	Height _____inches / cm Weight _____lb. / kg BMI percentile _____	
5.	Scoliosis Screening: _____Normal _____Abnormal _____Referred _____ No Referral	
6.	Activity Recommendation: _____Full Physical Activity _____Restricted Physical Activity (Must Complete Phys. Ed. Medical Exemption/Program Modification Form) Specify Restrictions:	

7.	List all medications currently being taken: Medication:_____ Reason:
8.	List ALL problems by history or examination: Circle status of problem 1. _____ Under Care Care Complete Referred 2. _____ Under Care Care Complete Referred 3. _____ Under Care Care Complete Referred _____No Problems Identified
Comments / follow-up treatment plan / Special instructions to school:	

Signature of Care Provider (REQUIRED)	Telephone	Care Provider office stamp (REQUIRED)
Address	Date of Exam	