



# Great Lakes Academy

6000 Custer Road, Building 7 \* Plano, Texas 75023

Phone: 972-517-7498 \* Fax: -2-517-0133 \* [www.greatlakesacademy.com](http://www.greatlakesacademy.com)

*Where Individuality and Differences are Celebrated!*

Entry Year \_\_\_\_\_

Entry Grade \_\_\_\_\_

## Child Information

Child's First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Sex: \_\_\_\_\_ Child Cell # \_\_\_\_\_

Custody: Student Resides with both parents  Parents Share Custody

One Parent with Primary Custody: \_\_\_\_\_  
Name Of Primary Parent

## Parent 1 Information

Parent / Guardian 1: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Cell #: \_\_\_\_\_ Marital Status:  married  divorced  separated  single

## Parent 2 Information

Parent / Guardian 2: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State/Zip \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Cell #: \_\_\_\_\_ Marital Status:  married  divorced  separated  single

## Testing

Psychoeducational Testing or FIE (Full Individual Evaluation) Date Tested: \_\_\_\_\_

Testing done by: \_\_\_\_\_

Other testing and date: \_\_\_\_\_

Other testing and date: \_\_\_\_\_

Diagnosis/Conditions: \_\_\_\_\_



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**Emergency Information**

Child's Full Name \_\_\_\_\_ DOB \_\_\_\_\_

I request that in my absence \_\_\_\_\_ be admitted to the closest available hospital for diagnosis and treatment. (Student Name)

I request and authorize physicians, dentist, and staff of the closest available hospital to perform any diagnostic procedures, treatment procedures, x-ray treatments, and anesthetics as may be necessary in the diagnosis and treatment of the above minor.

I have not been given a guarantee as to the results of examination or treatment. I authorize the closest available hospital to dispose of any specimen or tissue taken from the above named person.

Primary Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Illnesses**

List all medical conditions aside from learning differences.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**At Home Medications**

List below any medication taken **AT HOME** on a regular basis. **MANDATORY**

	<b>List mg/gr</b>	<b>am/pm</b>	<b>for treatment of</b>
Medication _____	Dosage _____	Time Given _____	For _____
Medication _____	Dosage _____	Time Given _____	For _____
Medication _____	Dosage _____	Time Given _____	For _____
Medication _____	Dosage _____	Time Given _____	For _____
Medication _____	Dosage _____	Time Given _____	For _____



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In order for school personnel to administer medication, the following requests are made:

Request to Administer OTC Medication

1. A medication check-in form is to be completed for each medication administered at school.
2. A written request from student's physician will be required when over-the-counter medication must be given longer than 10 consecutive days.
3. **All medication** must be in the original, properly labeled container accompanied by the Medication Check-In Form (*Texas Education Code 21:914*). Please request the pharmacist to dispense two labeled medication bottles (one for home and one for school).

Please list all **over-the-counter medications** you give GLA permission to administer to your child:

acetaminophen     ibuprofen     Clear Eyes/Tears     hydrocortisone  
 antihistamine     cough drops     Midol     Tums     Pepto Bismol

Any additional OTC medications are to be provided by the parent and signed in with the Medication Check-In Form.

Request to Administer Prescription Medication

Please list all **prescribed medications** you give GLA permission to administer to your child:

1. Medication \_\_\_\_\_ Dosage of Medication \_\_\_\_\_  
Number of pills/tsp. to administer \_\_\_\_\_ Day and Time to Administer \_\_\_\_\_
2. Medication \_\_\_\_\_ Dosage of Medication \_\_\_\_\_  
Number of pills/tsp. to administer \_\_\_\_\_ Day and Time to Administer \_\_\_\_\_
3. Medication \_\_\_\_\_ Dosage of Medication \_\_\_\_\_  
Number of pills/tsp. to administer \_\_\_\_\_ Day and Time to Administer \_\_\_\_\_
4. Medication \_\_\_\_\_ Dosage of Medication \_\_\_\_\_  
Number of pills/tsp. to administer \_\_\_\_\_ Day and Time to Administer \_\_\_\_\_

**I / We, the undersigned, give my/our permission for the staff of Great Lakes Academy to administer the medications listed on this sheet (including both over-the-counter and / or prescription) to my/our child.** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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Child's Full Name: \_\_\_\_\_

**Medical Alert Information**

Is your child allergic to any medications? If yes, please list allergy and reaction to expect.

\_\_\_\_\_  
\_\_\_\_\_

Is your child allergic to any foods? If yes, please list allergy and reaction to expect.

\_\_\_\_\_  
\_\_\_\_\_

Does your child require the use of an Epi Pen should he/she have an allergic reaction? \_\_\_\_\_  
If so, please have your child's physician complete the attached procedure form.

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Emergency Contacts**

Emergency Contact Information: (in the order to call)

1.	_____	_____	_____	_____
	Name	Relationship	Cell #	Alternate #
2.	_____	_____	_____	_____
	Name	Relationship	Cell #	Alternate #
3.	_____	_____	_____	_____
	Name	Relationship	Cell #	Alternate #
4.	_____	_____	_____	_____
	Name	Relationship	Cell #	Alternate #

**Please attach a current copy of your child's immunization record to accompany these pages.**



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## Transportation Form

Student Pick Up Persons

My child \_\_\_\_\_ Grade \_\_\_\_\_ may be picked up from GLA by:

1. \_\_\_\_\_  
Name of Person/Service/Day Care Relationship Phone Number
2. \_\_\_\_\_  
Name of Person/Service/Day Care Relationship Phone Number
3. \_\_\_\_\_  
Name of Person/Service/Day Care Relationship Phone Number
4. \_\_\_\_\_  
Name of Person/Service/Day Care Relationship Phone Number
5. \_\_\_\_\_  
Name of Person/Service/Day Care Relationship Phone Number

## General Waiver

General Waiver

My signature below verifies that I/we \_\_\_\_\_  
Name of Parent/Legal Guardian

am/are the legal guardian(s) of \_\_\_\_\_  
Child's Name

and that, as such, is under my/our control and in my/our custody. I desire my/our child to participate in any and all activities and/or go on any and all field trips, along with the staff, students, and volunteers of Great Lakes Academy during the school year. In consideration of said child being permitted to make such trips, or take part in such activities and the instruction my/our child will receive by reason thereof, I hereby release Great Lakes Academy, the directors, teachers, and employees, together with any volunteer carrier of such child without compensation, from any and all liability and responsibility in connection with such trips and activities, and hereby release all said parties from liability by reason of any accident or injury suffered by said child while on said trips or engaged in such activities.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please print and sign this page. Electronic signature is not accepted.**



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## Media Consent

Media Consent

This parental consent form serves to both inform you and to request permission for your child's photo/image or likeness, voice or creative work(s) to potentially be used by GLA on its website, school management system (RenWeb), or on a CD or any other electronic/digital media or print media. This may also include advertising brochures, and other media promoting and advertising services of Great Lakes Academy.

**As you are aware, there are potential dangers associated with the posting of personally identifiable information on a web site since global access to the Internet does not allow us to control who may access such information. These dangers have always existed; however, we, as a school, do want to celebrate your child and his/her work.**

Therefore, GLA **will not release** the following personally identifiable information: student last names (surnames), residential addresses, e-mail address, phone numbers, or location and time of class trips. Information within the GLA newsletter and on RenWeb is released only to GLA parents, and is not on public forums.

As the child's parent or legal guardian, I agree to release and hold harmless GLA, its members, trustees, agents, officers, contractors, volunteers, and employees from and against any and all claims, demands, actions, complaints, suits, or any other form of liability resulting from such use.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

month

year

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

## Release of Parental Information

I give Great Lakes Academy permission to release my phone number, and email address to other GLA parents.

Yes

No

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Yes

No

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Release of Parent Info



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## General Health Screening

General Health Screening

It is my understanding that Great Lakes Academy will have a general health screening which is required by the Texas Department of Health and done by Metroplex Educational Consultants. The general testing for vision, hearing, and diabetes/AN (acanthosis nigricans) is done in grades 1, 3, 5, and 7. Girls, grades 5<sup>th</sup> and 7<sup>th</sup>, and boys, grade 8 are required to have a spinal screening. If I have had these tests privately from June 1<sup>st</sup> to May 30<sup>th</sup> and can provide documentation, these tests will not be given. I will be notified of what tests my child will require at the time of the screening, and the cost that will be remitted from my child's activity fees. If my child is absent on the day of testing, I will have to get these tests done prior to May 30<sup>th</sup> to be in compliance with the law.

The cost for the tests is presently from \$9 to a total of \$35.

Child's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

City & State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Race/Ethnicity (for AN test): \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Testing to Be Done

### To be completed by the office:

### Required Tests

Vision \$\_\_\_\_

Hearing \$\_\_\_\_

Diabetes/AN \$\_\_\_\_

Spinal \$\_\_\_\_

for a total cost of \$\_\_\_\_\_ to be remitted from activity account.



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## Student Information Release Form

Student Information Release Form

First Name \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

DOB \_\_\_\_\_ Grade \_\_\_\_\_

To: \_\_\_\_\_ Fax # \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Last School Attended

\_\_\_\_\_ City, State & Zip

Address

The student listed above recently enrolled at Great Lakes Academy and reported to us that they formally attended your school. The following information would be helpful to us in assessing placement and progress.

Check the information to be released:

- Copy of birth certificate
- Vision, Hearing, AN, and Spinal Screening Results
- Educational Evaluations
- Psychoeducational Evaluation and/or FIE
- Speech/Language Evaluation
- Individual Educational Program/Plan (IEP)
- Standardized Test Data
- Transcript of Grades

Please mail, email, or fax these records as soon as possible to the Registrar at the above address.

**Permission for release of records for the above named student.**

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please print and sign this page. Electronic signature is not accepted.**





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Background Check

## Consent to Background Check

All Texas public schools are required by state law to obtain criminal history record information on all individuals who work or volunteer in the public school systems (Texas Education Code Section 21.97). For the safety of all our students, GLA requires the same of all volunteers. Thank you for your continued support and dedication to Great Lakes Academy. The information requested below is necessary to perform the criminal history background check.

**Student Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent / Guardian 1

## Parent/Guardian 1

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Maiden: \_\_\_\_\_ Last Previous Name: \_\_\_\_\_

DOB: \_\_\_\_\_  Male  Female Race/Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do you have a valid Texas Driver's License? \_\_\_\_\_ If not, list state for valid license: \_\_\_\_\_

License Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Guardian 1

Parent / Guardian 2

## Parent/Guardian 2

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Maiden: \_\_\_\_\_ Last Previous Name: \_\_\_\_\_

DOB: \_\_\_\_\_  Male  Female Race/Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do you have a valid Texas Driver's License? \_\_\_\_\_ If not, list state of valid license: \_\_\_\_\_

License Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Guardian 2



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**Aftercare Program**

## Aftercare Program

Great Lakes Academy provides aftercare Monday through Friday from 3:30 p.m. - 5:00 p.m. This service is for working parents who cannot pick up their student at regular dismissal times. Aftercare is a structured time to provide the students an opportunity to relax, play, have a snack, and start homework. This is not just an opportunity for kids to stay and play. The expectations for student behavior are the same as during the school day. GLA reserves the right to refuse this service to any student who does not comply with the rules.

**Fees/Billing**

- Fees:**
  - Aftercare Fee:** \$15.00 per day
  - Aftercare Late Fee:** \$3.00 per minute. A late fee is levied beginning at 5:01 (see note re: late fees below) and will be billed.
- Billing:** Parents will be billed monthly. All questions regarding billing should be directed to Ms. Borsten.
- Snacks:** Parents are responsible for their child's snack during aftercare. Please send a healthy Snack.
- Homework:** Students will start their homework and will be provided guidance by the teacher. However, each evening parents will still need to make sure everything is complete. Students may need help at home studying spelling words, vocabulary, math facts, or for a test.

**Aftercare Attendance**

**Student Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

My child will attend Aftercare:

- Monday \$15.00
- Tuesday \$15.00
- Wednesday \$15.00
- Thursday \$15.00
- Friday \$15.00

My child will attend Aftercare on an as-needed basis and understand that I need to contact the office at **972-517-7498 extension 100** to let the office know.

I understand that the late fee of \$3.00 per minute has been instituted in order to deter anyone from retrieving their child past 5:00 p.m. GLA recruits their regular teaching staff to provide aftercare and it is imperative that these individuals are able to get home to their families on time. Thank you. However, in case of an emergency or unforeseen event, I \_\_\_\_\_, acknowledge and agree to pay the late fee of \$3 per minute beginning at 5:01 p.m. \_\_\_\_\_ (Parent Initials)

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date