



4330 Clime Road North
Columbus, Ohio 43228
Phone: (614) 272-9392
Fax: (614) 272-8940

Enrollment Checklist

Items Needed for Enrollment:

- ☐ Enrollment Application
- ☐ Birth Certificate
- ☐ Social Security Card
- ☐ Proof of Residency (Lease, Utility Bill or Bank Statement within 30 days)
- ☐ Immunization Records
- ☐ Emergency Medical Form
- ☐ Lunch Application
- ☐ Request for Previous School Records
- ☐ Request for School Transportation Columbus or South-Western
- ☐ Home Language Survey
- ☐ Parent/Guardian Identification
- ☐ Legal Name Change (if applicable)
- ☐ Medicaid ID Card

Enrollment Checklist (For Office Use Only)

Student's Name: _____

SSID: _____ **District of Residence** _____

Anticipated StarDate: _____ **Actual Start Date:** _____

Date Received:

_____ Enrollment Application

_____ Birth Certificate

_____ Social Security Card

_____ Proof of Residency

(Lease, Utility Bill or Bank Statement within 30 days)

_____ Immunization Records

_____ Emergency Medical Form

_____ Lunch Application

_____ Request for Previous School Records

_____ Request for School Transportation

Columbus City Schools

South-Western City Schools

_____ Home Language Survey

_____ Parent/Guardian Identification

_____ Legal Name Change (if applicable)

Westside Academy

4330 Clime Road North
Columbus, OH 43228
Phone: 614-272-9392
Fax: 614-272-8940



Student Enrollment Application

KG ☐ Gr.1 ☐ Gr.2 ☐ Gr.3 ☐ Gr.4 ☐ Gr.5 ☐ Gr. 6 ☐ Gr. 7 ☐ Gr.8 ☐ Date: _____

Referral Contact Name and Phone Number: _____

Student Name: _____
First Middle Last

Address: _____ City: _____

State: _____ Zip Code: _____ Place of Birth: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Circle One: Male or Female Date of Birth: _____ Age: _____ years, _____ months

Last School Attended: _____ Last Grade: _____ Duration: _____

Address: _____ City: _____ State: _____ Zip: _____

Student Lives With (Please Check One)

Father and Mother ☐ Father ☐ Mother ☐ Other (Please specify) ☐ _____

Parent/Guardian Information

Father/Guardian Full Name: _____
First Middle Last

Address: _____ City: _____ State: _____ Zip Code: _____

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

Email: _____

Mother/Guardian Full Name: _____

First Middle Last

Address: _____ City: _____ State: _____ Zip Code: _____

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

Email: _____

Parent Signature: _____ Date: _____

For Office Use Only

☐ App ☐ BC ☐ SS ☐ POR ☐ Imm ☐ EMF ☐ Lunch ☐ PSR ☐ Bus ☐ HLS ☐ ID ☐ LNC

Application Received: _____ Date Approved: _____ Enrollment Date: _____

SSID: _____ EMIS ID: _____ District of Residence: _____

** Westside Academy maintains a non-discriminatory policy and admits students of any race, religion, and ethnic background to all the rights, privileges, and activities made available to students of Westside Academy. **

Health

Family Doctor: _____ Telephone: _____

Allergies: _____

Any Special Needs your Child Requires: _____

*Racial or Ethnic identity of your Child: _____ White/ Caucasian _____ Black/African-American _____ Hispanic/Latino
_____ Asian _____ Alaskan Native _____ Pacific Islander _____ Native-American _____ Multiracial

Is English the Primary Language spoken at Home? ☐ Yes or ☐ No

Does your child speak English? Yes or No

Does your child speak Somali? Yes or No

Does your child speak Arabic? Yes or No

Does your child speak Spanish? Yes or No

Does your child read or write English? Yes or No

Other Languages Spoken: _____

Has your child ever taken ESL Classes: Yes or No

If yes, Location of Classes: _____

Educational History

Has your child ever: (Please Circle One)

If Yes, Please Explain:

Attended another school in the United States? Yes or No

Attended Columbus City Schools? Yes or No

Attended South-Western City Schools? Yes or No

Been Suspended from School? Yes or No

Been Expelled from School? Yes or No

Received major disciplinary action? Yes or No

Received Psychological/Neurological Testing? Yes or No

Received Speech or Learning Disability Services? Yes or No

Have an active IEP? Yes or No

Attended an Academic Summer School? Yes or No

Held Back/Repeated a Grade? Yes or No

Skipped forward a grade? Yes or No

Received Special Honors or Awards? Yes or No

Belong to any Clubs or Organized Groups? Yes or No

Does your child read or write English? Yes or No

** Westside Academy maintains a non-discriminatory policy and admits students of any race, religion, and ethnic background to all the rights, privileges, and activities made available to students of Westside Academy. **

2026-2027

Emergency Medical Authorization Form

Westside Academy

Has Home/Phone Changed in the past year? ☐ Yes ☐ No

Please complete in BLUE OR BLACK INK



Teacher: _____ Student's Name: _____

Grade: _____ Street: _____

Date of Birth: _____ City: _____ Zip: _____

Home Phone #: _____ Mother's Cell #: _____ Father's Cell #: _____

Purpose – To enable parents, guardians, and alternate persons listed below, to authorize the provision of emergency treatment, including the administration of medication, for children who become ill or injured while under school authority, when parents and guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name _____ Place of Employment: _____

Lives with Student: ☐ Yes ☐ No Work Phone: _____

Ok to contact at work: ☐ Yes ☐ No

Father's Name _____ Place of Employment: _____

Lives with Student: ☐ Yes ☐ No Work Phone: _____

Ok to contact at work: ☐ Yes ☐ No

Guardian's Name _____ Place of Employment: _____

Lives with Student: ☐ Yes ☐ No Work Phone: _____

Ok to contact at work: ☐ Yes ☐ No

Alternate Persons to Notify:

Alt # 1 Name: _____ Relationship: _____

Address: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Alt # 2 Name: _____ Relationship: _____

Address: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Alt # 3 Name: _____ Relationship: _____

Address: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

FAMILY INFORMATION:

Student is living with:

☐ Both Parents ☐ Father ☐ Mother ☐ Guardian ☐ Step-Parent ☐ Other ☐ Foster Parent

Parents are: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married ☐ Widowed

Students and families who have temporary living arrangements:

☐ Shelter ☐ Unsheltered ☐ Shared Housing ☐ Hotel/Motel

If there is a court custody order pertaining to this child, who has custody? _____

(A copy of custody papers is Required to be on file.)

Emergency Medical Form

Page 1 of 2

PART I OR II MUST BE COMPLETED

NOTE: NO ONE will be permitted to pick up your child unless his/her name appears on this form, or we have written confirmation from Parent or Guardian. **This includes an evacuation or terrorist alert.**

PART I: TO GRANT CONSENT

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

Physician: _____ Telephone: _____

Dentist: _____ Telephone: _____

Medical Specialist: _____ Telephone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctors or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Please give facts concerning the student's medical history, including allergies and medications being taken:

Medical condition(s) we should be made aware of _____

Medicine student is currently taking (amount/when taken) _____

Allergies _____

Any other needed information regarding student _____

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

Note: This information will be shared with staff who have a legitimate educational need to know.

PART II: REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In cases in which the nature of an illness or an injury appears serious, the parent(s) are contacted and the instructions on this form are followed. In extreme emergencies, arrangements may be made for the student's immediate hospitalization whether or not the parent(s) can be reached. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

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



Westside Academy

Transfer Request for Student Records



Today's Date: _____

Student's Name: _____

Student's Date of Birth: _____

Student's Address: _____

City: _____ State: _____ Zip Code: _____

Previous School Information:

Previous School Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Start Date at Westside Academy: _____

The above student has applied for admission to Westside Academy.

Please forward the information below:

Attendance Information
Disciplinary Information
Grade Reports

Health information
IEP, ETR, 504 Plan, etc.
Academic Work Completed

Group Attitude
Birth Certificate
Test Scores

According to Federal Law (20 USC Sect. 1232g, commonly known as the Buckley Amendment), consent is not required in order for you to transfer these records. According to the Code of Federal Regulations (34 CFR 99.32a), such records are subject to disclosure to officials of another school or school system in which the student seeks or intends to enroll without the necessity of parental consent.

1st Attempt

Please Fax or Mail the above information to:

Westside Academy
4330 Clime Road North
Columbus, Ohio 43228
School Phone: (614) 272-9392
School Fax: (614) 272-8940

2nd Attempt

Language Usage Survey

Parents and Guardians: Ohio schools, in accordance with [The Every Student Succeeds Act](#), request all families complete a language usage survey when they enroll their student in school. This information will help school staff understand your child's language background and your family's preferred language communications to best support your child's learning. The information is not used to identify immigration status.

Student name (First and Last): _____

Student date of birth (mm/dd/yyyy): ____/____/____

Communication Preferences: <i>Indicate your language preference so an interpreter or translator may be provided at no cost.</i>	1. In what language(s) would your family prefer to communicate with the school?
Language Background <i>Information about your child's language background is needed to identify whether students are screened for English learner status.</i>	2. What language did your child learn first? 3. What language does your child use the most? 4. What languages are used in your home?
Prior Education. <i>Responses about your child's birth country and previous education provide information about the knowledge and skills your child is bringing to school.</i>	5. In what country was your child born? 6. Has your child ever studied or received formal education outside of the United States? ☐ Yes ☐ No a. If yes, how many years/months? b. If yes, what was the language of instruction? 7. Has your child attended school in the United States? ☐ Yes ☐ No a. If yes, when did your child first attend school in the United States? (mm/dd/yyyy): ____/____/____
Additional Information. <i>Share any information to better understand your child's language experiences and background.</i>	
Parent/Guardian name (First and Last): _____	
Parent/Guardian Signature: _____ Today's Date: (mm/dd/yyyy): _____	

Somali | Xog-ururinta Isticmaalka Luuqadda

Waaliddiinta iyo Masuulada: Xog-ururinta luuqadda oo dhammaystiran waxa laga rabaa dhammaan ardayda markii ay isku qoraan dugsigada Ohio. Macluumaadkan waxay u sheegi doonaan shaqaalaha dugsiga haddii ay u baahan yihiin inay hubiyaan sida ilmahaagu luuqadda Ingiriisida ku yahay. Jawaabaha su'aalaha waxay xaqiijiyaan in ilmahaagu helo adeegyada waxbarashada si uu dugsiga ugu guulaysto. Macluumaadkan looma isticmaalo in lagu garto xaaladda muhaajirnimada (socdaalka) ee qofka.

Waad ku mahadsan tahay bixinta macluumaadka kore. La xidhiidh dugsigaaga ama xafiiska degmada haddii aad qabto su'aalo ku saabsan foomkan

Magaca Ardayga: (Magaca Hore iyo Magaca Dambe)		Taariikhda Dhalashada Ardayga: (bisha/maalinta/sanadka)	
Doorashooyinka Wada-xiriirka Sheeg luuqadda aad doorbidayso si aanu kuugu diyaarin karno tarjumaan ama waraaqo tarjuman oo lacag la'aan ah markii aad u baahato. Dhammaan waaliddiintu waxay xaq u leeyihiin inay ku helaan macluumaadka ku saabsan waxbarashada ilmahooda luuqad ay fahmayaan.	1. Waa maxay luuqadda qoyskaagu doorbidi lahaa inuu dugsiga kula xidhiidho? _____		
Taariikhda Luuqadeed Macluumaadka ku saabsan taariikhda luuqadeed ee ilmahaagu waxay naga caawinaysaa inaanu aqoonsano ardayda u qalanta taageero si loo kobciyo xirfadahooda xagga luuqadda ee daruuriga u ah guulaysiga dugsiga. In imtixaan laga qaado ayaa muhiim noqon karta si loo go'aamiyo haddii taageero xagga luuqadda ah loo baahan yahay.	2. Waa maxay luuqadda ilmahaagu ugu horrayn uu bartay? 3. Waa maxay luuqadda ilmahaagu uu inta badan ku hadlo marka guriga uu joogo? 4. Waa maxay luuqadaha lagaga hadlo gurigaaga?		
Waxbarashada Hore Jawaabaha ku saabsan waddanka ilmahaagu ku dhashay iyo waxbarashada hore waxay na siinaysaa macluumaad kusaabsan aqoonta iyo xirfadaha ilmahaagu la imanayo dugsiga oo awoodsiin kara in dugsigu helo maalgalin dheeraad ah si loo taageero ilmahaaga.	5. Waa maxay waddanka ilmahaagu ku dhashay? _____ 6. Ilmahaagu waligii ma ku helay waxbarasho toos ah dibadda Maraykanka? ☐ Haa ☐ Maya Haddii ay haa tahay, imisa sano/bilood? _____ Haddii ay haa tahay, waa maxay luuqadda wax lagu bari jiray? _____ 7. Ilmahaagu dugsiga ma ka dhigtay Maraykanka? ☐ Haa ☐ Maya Haddii ay haa tahay, goorma ayuu ilmahaagu markii ugu horraysay xadiray dugsi ku yaala Maraykanka? _____ / _____ / _____ Bisha Maalinta Sanadka		
Macluumaad Dheeraad Ah Fadlan nala wadaag macluumaad dheeraad ah si ay nooga caawiyaan inaanu fahamno waayo-aragnimada xagga luuqadda iyo taariikhda waxbarasho ee ilmahaaga.			
Magaca Hore ee Waalidka/Masuulka: _____		Magaca Dambe ee Waalidka/Masuulka: _____	
Saxeexa Waalidka/Masuulka: _____		Taariikhda Maanta: (bisha/maalinta/sanadka) _____	

ama ku saabsan adeegyada laga heli karo dugsiga ilmahaaga.

Spanish | Encuesta de uso del lenguaje

Padres y tutores: Se requiere una encuesta de uso del idioma completa para todos los alumnos al momento de la inscripción en las escuelas de Ohio. Esta información servirá para que el personal de la escuela sepa si necesitan verificar el dominio de inglés de su hijo/a. Las respuestas a estas preguntas aseguran que su hijo/a reciba los servicios educativos necesarios para tener éxito en la escuela. La información no se usa para identificar condición de inmigración.

Nombre del alumno: (nombre y apellido)		Fecha de nacimiento del alumno: (mm/dd/aaaa)	
Preferencias de comunicación. Indique su preferencia de idioma para que podamos proveer un intérprete o documentos traducidos sin costo cuando los necesite. Todos los padres tienen derecho a obtener información sobre la educación de sus hijos en un idioma que entiendan.		1. ¿En qué idioma(s) preferiría su familia comunicarse con la escuela? _____	
Antecedentes del idioma. La información sobre los antecedentes del idioma de su hijo/a nos ayuda a identificar a los alumnos que cumplen las condiciones para recibir apoyo para desarrollar las habilidades lingüísticas necesarias para tener éxito en la escuela. Puede ser necesario realizar pruebas para determinar si se necesitan apoyos para aprender el idioma.		2. ¿Qué idioma aprendió primero su hijo/a? _____ 3. ¿Qué idioma usa más su hijo en casa? _____ 4. ¿Qué idiomas se usan en su casa? _____	
Educación previa. Las respuestas sobre el país de nacimiento de su hijo/a y la educación anterior nos brindan información sobre los conocimientos y habilidades que su hijo está trayendo a la escuela y pueden permitir que la escuela reciba fondos adicionales para apoyar a su hijo/a.		5. ¿En qué país nació su hijo/a? _____ 6. ¿Ha recibido su hijo/a educación formal fuera de los Estados Unidos? ☐ Sí ☐ No En caso afirmativo, ¿cuántos años/meses? _____ En caso afirmativo, ¿cuál fue el idioma de instrucción? ____ 7. ¿Ha asistido su hijo a la escuela en los Estados Unidos? ☐ Sí ☐ No En caso afirmativo, ¿cuándo asistió su hijo por primera vez a la escuela en los Estados Unidos? _____/_____/_____ Mes Día Año	
Información adicional. Comparta información adicional para ayudarnos a comprender las experiencias de idioma y los antecedentes educativos de su hijo/a.			
Nombre del padre/tutor: _____ Apellido del padre/tutor: _____ Firma del padre/tutor: _____ Fecha de hoy: (mm/dd/aaaa) _____			

Gracias por brindar la información precedente. Comuníquese con su escuela u oficina del distrito si tiene preguntas sobre este formulario o sobre los servicios disponibles en la escuela de su hijo/a.

ONE-TIME PARENT CONSENT TO ACCESS PUBLIC BENEFITS (MEDICAID)

(For School-Based Medicaid Reimbursement — IDEA & FERPA Compliant)

School District: Westside Academy

Student Name: _____ **Date of Birth:** _____

Why You Are Receiving This Form

Your school district is allowed to request Medicaid reimbursement for certain health related services provided to your child at school. These services may include nursing services, therapies (speech, OT, PT), counseling, behavioral health services, and other medically necessary supports your child receives in school.

Before the district can bill Medicaid for the first time, **federal law requires the district to obtain your one-time written consent**. After you sign, the district must provide you with **annual written notification**, but you will **not** be asked to sign again.

Information That May Be Shared with Medicaid

To submit Medicaid claims, the district may share the minimum information required, including:

- Student name
- Date of birth
- Gender
- Medicaid ID (if applicable)
- Type of service provided
- Date/time of service
- Name/title of the provider delivering the service

No other information will be shared without your permission.

Important Protections for You and Your Child

Federal regulations guarantee the following protections:

No Cost to You

You **cannot** be charged:

- Deductibles
- Co-pays
- Premium increases
- Any out-of-pocket expenses

If a cost occurs, the district must pay it.

No Impact on Your Child's Medicaid Benefits

Allowing the district to bill Medicaid will **NOT**:

- Reduce your child's lifetime coverage
- Limit the number of services your child can receive
- Affect your child's eligibility for Medicaid
- Affect your family's use of Medicaid outside school

No Impact on School Services

Your child will continue to receive all required services at **no cost to you**, even if:

- You refuse to give consent
- You later withdraw consent

You May Withdraw Consent at Any Time

You may revoke consent at any time without penalty. Billing must stop immediately after you withdraw consent.

Consent Is Voluntary

You are **not required** to sign up for Medicaid, nor are you required to provide consent for your child to receive IEP or other school-based services.

Parent/Guardian Consent (Select One)

- ☐ **YES, I give consent** for the school district to share the information listed above and to access my child's Medicaid benefits to receive reimbursement for school-based health services.
- ☐ **NO, I do not give consent.** I understand that my child will still receive all required services at no cost to me.

Your Rights

By signing this form, you acknowledge:

- You understand what information will be shared.
- You understand your rights and protections under federal law.
- You understand consent is voluntary and may be revoked at any time.
- You understand your child's services will not be impacted by your decision.

Parent/Guardian Information

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____

Effective Date: __7__ / __01__ / __2026__

Phone/Email (optional): _____

ANNUAL NOTIFICATION OF SCHOOL DISTRICT PARTICIPATION IN MEDICAID

School District: Westside Academy

School Year: 2026-2027

Dear Parent/Guardian,

This letter serves as the **Annual Notification** that the **Westside Academy** participates in the **School Based Medicaid Program**. This program allows school districts to receive federal Medicaid reimbursement for providing certain health related services to students who are Medicaid eligible. This notification is required by federal law and must be provided **every year**, even if you have already signed the **One-time Parental Consent** form. You do **not** need to sign anything today.

Why You Are Receiving This Annual Notification

Federal regulations require school districts to provide parents with yearly written notice explaining their rights before and after Medicaid is billed for school based services. Even if you have already given **One-time Consent**, districts must continue to send you this annual notice. You do *not* need to sign the consent again.

What Participation in Medicaid Means

If your child is eligible for Medicaid, the district may request reimbursement for medically necessary services delivered at school, such as:

- Speech therapy
- Audiology Services
- Occupational therapy
- Physical therapy
- Nursing services
- Counseling and behavioral health services
- Other health related services covered by Medicaid

Only the **minimum necessary information** required to access Medicaid reimbursement is shared, including:

- Student name
- Date of birth
- Medicaid ID
- Type/date/provider of service

Your Rights and Protections Under Federal Law

No Cost to You

Allowing the district to access Medicaid **will not**:

- Result in co-pays or deductibles
- Reduce lifetime coverage
- Increase premiums
- Limit services available to your child outside school

If any cost were to occur, the school district would be responsible for it—not you.

Your Child's Services Are Not Affected

Your child will receive all required services **at no cost to you**, whether you allow the school to bill Medicaid. Refusing or withdrawing consent **cannot** affect your child's access to IEP or related services.

You May Withdraw Consent at Any Time

If you previously gave one-time consent, you may revoke it at any time.

When you revoke consent, the district must stop billing Medicaid.

No Impact on Medicaid Eligibility

Your consent **does not** affect:

- Your child's future eligibility
- Your family's benefits
- Enrollment in Medicaid

Action Needed:

None. This notification does not require a response.

This letter is for notification only. You do **not** need to return or sign anything unless the district requests updated consent because no consent is currently on file.

If your child is new to the district or has never had a Medicaid consent form completed, you may be asked to complete the **One-time Parent Consent** form separately.

Questions?

If you have questions about Medicaid services, billing, or your rights, please contact:

District Medicaid Contact: Heather O'Bannon, Director

Phone: 614-272-9392

Email: hobannon@wsa-school.com

Thank you for your partnership in supporting student health and well-being.