



**REGISTRATION CHECK LIST**

- Withdrawal documents from previous school. (Does not apply to incoming Kindergarten students)
- Official Transcripts (FOR HIGH SCHOOL STUDENTS)
- Birth Certificate
- Social Security Card
- Immunization/Shot Record (Updated)
- TB/(PPD) with results read within the year for all entering students. (If your child's skin test is positive, clearance from DPHSS is required)
- Physical Exam

**RELEASE OF RECORDS FORM**

Permission is hereby granted to:

Previous School Name: \_\_\_\_\_

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

Student Name: \_\_\_\_\_ Grade: \_\_\_\_ SY \_\_\_\_\_

The above named student has registered at Guahan Academy Charter School.

Please release the following information:

- Grades
- Health Records
- Results of Achievements and intelligence test.
- Personality rating and other similarity data.
- Grades in progress at time of leaving.
- Any other material pertinent to the growth of the student.
- Any psychological testing or Child Study Team information, including the most recent.
  - ❖ Education evaluation
  - ❖ Psychological assessment
  - ❖ Social worker history

Written information is to be sent to the attention of:

**Guahan Academy Charter School  
P.O.Box CS, Hagatna, Guam 96932**

**Authorization to release child(ren) records:**

**I have enrolled my child \_\_\_\_\_ at Guahan Academy Charter School and authorize you to release the above named student his/her school documents.**

**Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_**

**GUAHAN ACADEMY MISSION STATEMENT**

At Guahan Academy Charter School, our mission is to empower our students with proven educational practices and social support to be productive citizens in the community.



## Expected Schoolwide Learner Outcomes

GACS STUDENTS WILL BE:

Goal Oriented Active Communicators and Critical Thinkers who Strive for Lifelong Success



### STUDENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Gender: \_\_\_\_\_ Citizenship: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_

Birth Place: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Student has an IEP? Yes \_\_\_ N \_\_\_

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

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

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

### PARENT/GUARDIAN INFORMATION

#### FATHER

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Home Address (If different from above) \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

#### MOTHER

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Home Address (If different from above) \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

#### LEGAL GUARDIAN

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Home Address (If different from above) \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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MEDIA CONSENT FORM

Dear Parents/Guardians,

Throughout the school year, there will be occasions when photographs of the school and your child may be taken by school personnel or the media. Your authorization is requested to have your child photographed or videotaped for media and/or school publications such as newspapers, television, radio, brochures, newsletters, website and for educational documentation of learning activities.

Highlights of our students' achievements and our school activities can be viewed throughout the year on Guahan Academy Charter School's website at www.guahanacademy.org. Individual or group photos of students will be posted on the school website to showcase particular events or activities. General pictures on the website will not identify students by name. Students will only be identified by name when local press releases are made to highlight student achievements.

By giving your permission, you are helping the school to share and promote our students' accomplishments and gain support from the community!

-Guahan Academy Charter School

[ ] YES Permission is given for my child to be photographed or videotaped for media and/or school publications such as newspapers, television, radio, brochures, newsletters, website, and for educational documentation of learning activities.

[ ] NO Permission is given for my child to be photographed or videotaped for media and/or school publications such as newspapers, television, radio, brochures, newsletters, website, and for educational documentation of learning activities.

Parent/Legal Guardian Name (Print) Parent/Legal Guardian Signature Date

This media consent form is effective for (Print student name) until revoked by parent/guardian.

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### HOME LANGUAGE SURVEY

1. What language did your son or daughter speak when he or she first began to talk? \_\_\_\_\_
2. What language does your son or daughter most frequently speak at home? \_\_\_\_\_
3. What language does your son or daughter most speak frequently with friends? \_\_\_\_\_
4. What language do you use most frequently to speak to your son or daughter? \_\_\_\_\_
5. Name the language(s) most often spoken by the adults at home. \_\_\_\_\_

I, \_\_\_\_\_, certify that the above statements made in the Home Language Survey are true and correct.

Parent/Legal Guardian: \_\_\_\_\_  
Print Name Signature Date

### TRANSPORTATION

Please draw a map below to best explain the location of your residence. This information may be shared with DPW for bus route planning purposes.

Physical/Home Address: \_\_\_\_\_

Will your child(ren) ride bus? Morning Only \_\_\_ Afternoon Only \_\_\_ Both Morning & Afternoon \_\_\_

Will your child(ren) be a car rider? Morning Only \_\_\_ Afternoon Only \_\_\_ Both Morning & Afternoon \_\_\_

Will your child be attending the STARS Afterschool Program? Yes \_\_\_ No \_\_\_ \*Stars Registration form required.

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STUDENT EMERGENCY CARD (To be COMPLETED by PARENTS or GUARDIANS)

Student Name: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade \_\_\_\_\_

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

Father/Guardian Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother/Guardian Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

Home Address: (If different from above) \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

I hereby give permission to the school to release my child(ren) to any of the following persons in the event I am unable to pick up my child.

PERSONNEL AUTHORIZED TO PICK UP STUDENT

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_

- In an emergency, I give permission for the ambulance to transport my child to \_\_\_ GMH \_\_\_ NAVAL HOSPITAL \_\_\_ GRMC
➤ My child is able to participate in regular Physical Education classes: Yes \_\_\_ No \_\_\_
➤ If the answer is NO, a doctor's note is required. Has this been provided? Yes \_\_\_ No \_\_\_
➤ In the event of a food borne illness, GACS & DPHSS are authorized to obtain stool/vomit samples from my child in the interest of Public Health. Yes \_\_\_ No \_\_\_

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HEALTH HISTORY

ALLERGIES: (Please indicate type of ALLERGIES and the student's REACTION below if ANY.)

- ( ) NO KNOWN Allergies
( ) Food: \_\_\_\_\_ Reaction: \_\_\_\_\_
( ) Drug: \_\_\_\_\_ Reaction: \_\_\_\_\_
( ) Bee Stings ( ) Insect Bites Reaction: \_\_\_\_\_
( ) Seasonal Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_
( ) Other NOT LISTED above: \_\_\_\_\_ Reaction: \_\_\_\_\_
( ) Used EpiPen for Reaction: Yes \_\_\_ No \_\_\_ ( ) UC or ER visit for reaction Yes \_\_\_ No \_\_\_

PLEASE (✓) CHECK MARK ALL THAT IS APPLICABLE TO YOUR CHILD.

Table with 6 columns: YES, NO, MEDICAL PROBLEM, YES, NO, MEDICAL PROBLEM. Rows include Rheumatic Fever, Diabetes, Heart Disease, Chicken Pox, Mumps, Measles, Tuberculosis, Anemia.

Please EXPLAIN if you answer YES to any of the questions BELOW.

Table with 3 columns: YES, NO, MEDICAL PROBLEM. Rows include Epilepsy (Seizures), Seizure due to High Fever, Asthma, Skin Problems, Ear/Hearing Problem, Vision Problem, On Medication, Serious ILLNESS or INJURY, PHYSICAL or MENTAL Problems, Other MEDICAL PROBLEM not listed above.

Parent/Legal Guardian Name (Print): \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\*\*It is important to notify the SCHOOL HEALTH COUNSELOR or PRINCIPAL of any pertinent change in health status, temporary or otherwise. \*\*

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## PHYSICAL EXAMINATION FORM

New Enrollment: \_\_\_ Entering Kinder: \_\_\_ Entering 6<sup>th</sup> Grade: \_\_\_ Entering 9<sup>th</sup> Grade: \_\_\_

**NOTE: Other physical examination forms used by medical clinics may be used in lieu of this form. A copy of the Official Immunization Record must be attached with this Form or provided to GACS Staff upon submission.**

<b>Student First Name</b>	<b>Student Last Name</b>	<b>Date of Birth</b>	<b>Village</b>
<b>Home Address:</b> _____			
<b>Mailing Address:</b> _____			
<b>Father/Guardian Name:</b> _____		<b>Mother/Guardian Name:</b> _____	

### PHYSICAL EXAMINATION RESULTS

**\*\*TO BE COMPLETED BY A MEDICAL PROFESSIONAL\*\***

HT: \_\_\_\_\_ WT: \_\_\_\_\_ T-P-R: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ BP: \_\_\_\_\_ O2 Sat: \_\_\_\_\_

VISION	NEAR	FAR	Hearing	Left	Right
No Correction					
With Correction					

	NORMAL	ABNORMAL	NOT EXAMINED	DESCRIPTION OF ABNORMAL FINDINGS:
General Appearance				
Skin, Hair and Nails				
Eyes: External (Pupils, Cornea)				
Optic Fundus				
Muscle Balance				
Ears: External				
Optic Fundus				
Muscle Balance				
Nose, Mouth, Pharynx, Larynx				
Speech				
Teeth, Gums				
Neck, Lymph Nodes, Thyroid				
Cardiovascular				
Respiratory				
Gastro Intestinal				
Genito - Urinary				
Muscular Skeletal				
Scoliosis Screening				
Neurological Impressions				
Nutritional Status				
Other				

Diagnosis/Findings	Advice & Treatment Given	Recommendations & Follow-Up Plan

Is this student physically fit to participate in physical education and/or athletic events & related activities? YES NO

Examiner's Name (Print): \_\_\_\_\_ Clinic: \_\_\_\_\_ Clinic Phone #: \_\_\_\_\_

Signature of Examiner: \_\_\_\_\_ Date of Examination: \_\_\_\_\_

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