Welcome to Dover Middle School
Study Plus 2019-20
Study Plus Start Date: TUESDAY, Sept 24th

Dear Study Plus Parents/Guardians,

Please complete the attached packet and have your child return it to school **no later than Wed., Sept. 11, 2019. T**his packet contains paperwork that is extremely important that we have filled out and returned to school before the start of the program. **If we do not have a completed packet, your child cannot stay for the program until it is turned in.** Thank you for your cooperation in this matter.

Weekly Schedule: Monday-Thursday only
2:30 - 3:30 - Academics and snacks
3:30-4:30 - A variety of organized activities will be offered for those staying the extra 45 minutes

Your son/daughter is signed up for the Study Plus Program, so it is important that he/she is in attendance each day. If there are circumstances (like a doctor's appointment), please send a note to school with your child and the absence from Study Plus will be excused. The note can be turned into the office. You can also call the office to leave a message for Ms. Krause or send an email to krausem@dovertornadoes.com if your child will not be in attendance.

If you have any questions, do not hesitate to call the Middle School (330.364.7121) or email Ms. Krause (krausem@dovertornadoes.com).

Name: _____ Homeroom: _____

____ Option A: 2:30-3:30 Monday – Thursday ***

____ Option B: 2:30-4:30 Monday -Thursday Bus*____ Walk ____ Ride ____
**Circle your best drop off point*

Dover Ave	South Elem.	East Elem.	High School
Fire station	Superior Mobile Homes		rural location

***** NO transportation is available for option A**

21ST CENTURY

ENROLLMENT FORM
2019-2020

STUDENT NAME	PARENT OR GUARDIAN & RELATIONSHIP
ADDRESS	TELEPHONE
CITY/ZIP	SOCIAL SECURITY NUMBER
DATE OF BIRTH SCHOOL	TEACHER GRADE
MOTHER'S NAME	FATHER'S NAME
MOTHER'S BUSINESS ADDRESS	FATHER'S BUSINESS ADDRESS
MOTHER'S BUSINESS PHONE	FATHER'S BUSINESS PHONE

Does the student qualify for free or reduced lunch? □ Yes □ No

Does the student have an Individualized Education Plan (IEP)? □ Yes □ No

Is the student gifted/talented? □ Yes □ No

Student Ethnicity: □ Hispanic □Non-Hispanic

Student Race: □ White □ Black/African American □ Asian □ Native Hawaiian/Pacific Islander □ American Indian/Native Alaskan □ Other

Additional Comments:

Internal Use Only

Program Days: □ M □ T □ W □ Th □ F □ Other: _____

Areas Assigned: □ Math □ Reading □ Both

Verified by: _____ Date: _____

DOVER CITY SCHOOLS

21ST CENTURY

EMERGENCY MEDICAL AUTHORIZATION
2019-2020

STUDENT NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
CITY/ZIP	SCHOOL
GRADE LEVEL	TEACHER

RESIDENTIAL PARENT/GUARDIAN INFORMATION

Name _____ Home Phone_____

Relationship _____ Cell Phone _____

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

ADDITIONAL EMERGENCY CONTACT INFORMATION

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

Is this person authorized to pick up the student? □ Yes □ No

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

Is this person authorized to pick up the student? □ Yes □ No

ADDITIONAL PEOPLE AUTHORIZED TO PICK UP THIS STUDENT

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

Name _____ Home Phone _____

Relationship _____ Cell Phone _____

PART I OR PART II MUST BE COMPLETED

Part I – To Grant Consent

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 Dr. _____/_____ or Dr. _____/_____ (preferred physician) (phone no.) (preferred dentist) (phone no.) 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 _____/_____ or any other (preferred hospital) (phone no.) 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 to which school personnel/physician should be alerted: _____

_____

_____

_____ *_____

DATE SIGNATURE OF PARENT OR GUARDIAN

(MUST BE SIGNED)

****

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

Part II – Refusal to 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 authorities to take the following action: _____

_____

DATE _____ SIGNATURE _____ADDRESS_____