



# COMPASS CLASSICAL ACADEMY

A PUBLIC CHARTER SCHOOL

15 Elkins St. Franklin, NH 03235

Tel: 603-729-3370

Email: [info@compassclassicalacademy.com](mailto:info@compassclassicalacademy.com)

Web: <http://compassclassicalacademy.com>

## Application for Admission 2018-2019

**Application Timeline and Process:** We are accepting applications now for the 2018-2019 school year. Our open enrollment period is from November 15<sup>th</sup>, 2018 to March 31<sup>st</sup> 2019. If more students apply than Compass Classical Academy can accept, then a lottery will be conducted for spaces. Students not selected by the lottery will be put on a wait list. When openings become available, students on the waitlist will have the first chance to enroll. Applications are being accepted for grades kindergarten through 8<sup>th</sup>. Students must be age 5 by September 30, 2018 to enroll in Kindergarten.

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

Male  Female

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
MM/DD/YYYY City State Country

Current Grade this School Year \_\_\_\_\_ Grade Applying for: 

K	1	2	3	4	5	6	7	8

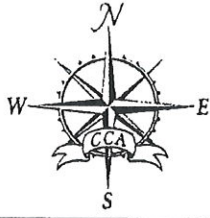
Current School Name: \_\_\_\_\_

Current School Address: \_\_\_\_\_

	Parent/Legal Guardian 1		Parent/Legal Guardian 2
Name:	_____	_____	_____
Home Address:	_____	_____	_____
Home Phone:	_____	_____	_____
Cell Phone:	_____	_____	_____
Email Address:	_____	_____	_____

Parent/Legal Guardian 1 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian 2 Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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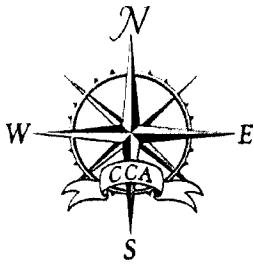
## STUDENT REGISTRATION FORM

Student Information			
Last Name _____	First _____	Middle _____	Grade _____
Home Address _____		Home Phone _____	
Date of Birth _____	Place of Birth _____	Gender _____	
Student Lives with _____			

Contact Information	
Parent / Legal Guardian #1 _____	Home Phone _____
Address _____	Cell Phone _____
_____	Employer Name _____
Email Address _____	Employer Phone _____
Relationship to Student _____	
Parent Legal Guardian #2 _____	Home Phone _____
Address _____	Cell Phone _____
_____	Employer Name _____
Email Address _____	Employer Phone _____
Relationship to Student _____	

Emergency Contacts	
(Adults other than those listed as legal guardians above who are willing to assume temporary care of your child and who will be contacted if we are unable to contact a parent or guardian.)	
1. Full Name _____	Daytime Phone _____
Relationship _____	Cell Phone _____
2. Full Name _____	Daytime Phone _____
Relationship _____	Cell Phone _____
3. Full Name _____	Daytime Phone _____
Relationship _____	Cell Phone _____

Are there any restrictions regarding dismissals, visitations or information on your child?	Yes	No
If yes, explain _____		
If there are any legal restrictions for the school to observe, i.e. custody/guardianship orders or protection orders, Compass Classical Academy must be provided with the appropriate legal documentation.		



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## Video/Photo Release Form

The **Compass Classical Academy Charter School** would like to include photos and videos of students, teachers, and school activities on its website and for the purpose of documenting or publicizing the Compass Classical Academy's Program. This may include various social media. Though the names of faculty, staff, and administration will regularly be used, it is our policy that the full names of students will not. Occasionally, it might be necessary to use the first name of a student, but no last names, addresses, and/or telephone numbers will ever be used.

I hereby give permission for Compass Classical Academy to use photos and videos along with my child's first name on Compass Classical Academy's website and other electronic forms of communication.

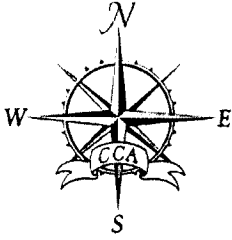
I hereby give permission for Compass Classical Academy to use photos and videos **without my child's first name** on Compass Classical Academy's website and other electronic forms of communication.

I hereby **do not** give permission for Compass Classical Academy to use photos or video on Compass Classical Academy's website and other electronic forms of communication.

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

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



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## STUDENT CLASSROOM INFORMATION

We feel that it is important that our school community has the opportunity to grow. One of the ways to make this possible is to provide parents with the information needed to contact one another.

The information supplied on this form will be distributed to your child's grade only. This information may be used only for school-related activities and contacts for friendships outside of school.

\_\_\_\_\_ I **give my permission** to have the information provided on this form distributed to my child's grade.

\_\_\_\_\_ I prefer that my contact information **not be distributed** to my child's grade.

**Indicate below the information that you would like to share.**

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

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

Parent/ Legal Guardian #1: \_\_\_\_\_

Parent/ Legal Guardian #2: \_\_\_\_\_

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

Phone Numbers:

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

Guardian #1

Guardian #2

Cell: \_\_\_\_\_

Cell: \_\_\_\_\_

Other: \_\_\_\_\_

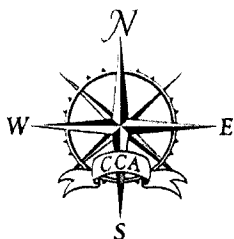
Other: \_\_\_\_\_

E-mail: \_\_\_\_\_

E-mail: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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Dear Parent or Guardian:

Each year, every school district in New Hampshire is required to report student data by race and ethnicity categories, set by the federal government, to the New Hampshire Department of Education (NHDOE). Though the NHDOE does not report individual student data to the federal government, the total number of students in various categories of each school is reported.

Recently, the federal government adjusted the student data reporting categories. With the new reporting categories, you will need to update your child's data.

Please update your child's student data, by completing the form below. If we do not receive a response from you, an employee of the district will be required to provide this information based on observation. (Note that federal regulations no longer permit districts to use a "not reported" code.)

Student's name: \_\_\_\_\_ Grade: \_\_\_\_\_

Please answer BOTH part A and B.

Part A. **Is this student Hispanic/Latino?** (Choose only one)

\_\_\_\_\_ **No, not Hispanic/ Latino**

\_\_\_\_\_ **Yes, Hispanic/ Latino** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

The above part of the question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate what you consider your child's race to be.

Part B. **What is the student's race?** (Choose one or more)

\_\_\_\_\_ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)

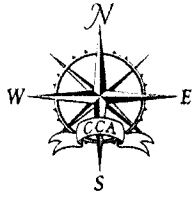
\_\_\_\_\_ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

\_\_\_\_\_ **Black or African American** (A person having origins in any of the black racial groups of Africa.)

\_\_\_\_\_ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

\_\_\_\_\_ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

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



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## PHYSICIAN'S REPORT OF ROUTINE PHYSICAL EXAMINATION

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_

### PHYSICAL EXAMINATION

Height: _____	Weight: _____	Hemoglobin: _____
Eyes: _____	Vision: _____	Glands: (specify) _____
Ears: _____	Hearing: _____	Heart: _____
Nose: _____	Blood Pressure: _____	Lungs: _____
Teeth: Temporary _____		Orthopedic: _____
Permanent _____		Skin: _____
Tonsils: _____		Hernia: _____
Nutrition: _____		Nervous System: _____
Allergies: _____		(Specify if Epilepsy) _____

Date of last hearing and vision screening: \_\_\_\_\_

Recommendations and/or special instructions: Previous Diseases and Operations, Allergies etc.: \_\_\_\_\_

Is this child capable of carrying a full program of school work including gymnastics and athletics?	YES	NO
Must the school program be modified to meet the needs of this child?	YES	NO
Any restrictions of use of stairs?	YES	NO
Any special seating accommodations?	YES	NO
Any rest periods?	YES	NO
Other? _____		

**PLEASE ATTACH IMMUNIZATION RECORD TO THIS REPORT**

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Phone Number

## Health Office Emergency Information

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

**Emergency Contacts:**

#1 \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

#2 \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

#3 \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

We will make every effort to reach you via phone/cell.

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

I have submitted my child's:	Yes	No
Physical dated within 1 year	___	___
Current immunization record	___	___
Current CCA Medical History Form	___	___

Health Concerns / Disabilities / Medical Problems:

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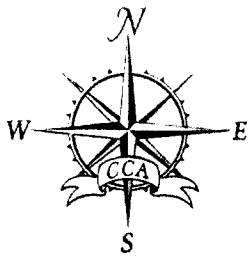
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The ultimate responsibility for medical care of a student rests with the parent/guardian. In event of an emergency, the Franklin Emergency Services (EMS) may be called to evaluate the injured / ill student. Parents/Guardians will be notified when an emergency occurs.

I give permission for health information to be shared with members of the school staff who have responsibility for my child. I understand that it is my responsibility to notify the school nurse of any change in medical status, medications or allergies.

Parent / Guardian Printed Name : \_\_\_\_\_

Parent / Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Medical History

Student Name \_\_\_\_\_

Student Date of Birth \_\_\_\_\_

Does the student have?	Yes	No
Asthma .....	___	___
Seizures .....	___	___
Diabetes .....	___	___
Hearing Problems .....	___	___
Vision Problems .....	___	___

Allergies	Yes	No
Bees .....	___	___
Environmental .....	___	___
Seasonal .....	___	___
Food(s) .....	___	___
Medication(s) .....	___	___

List food(s) and/or Medication(s) and type of reaction.

Does the student use?

Inhaler at School .....	___	___
Epi-Pen for allergic Reactions --	___	___

Current Medications (Please List)	Home	School
_____	___	___
_____	___	___
_____	___	___
_____	___	___

IF YOU INDICATE ABOVE THAT YOUR CHILD IS IN NEED OF AN EMERGENCY MEDICATION AT SCHOOL, WE WILL REQUIRE THESE BE MADE AVAILABLE TO US WITH A PHYSICIAN'S ORDER BY THE FIRST DAY OF SCHOOL.

May we have permission to give:	Yes	No
Tylenol (pain or fever) .....	___	___
Ibuprofen .....	___	___
Tums (indigestion) .....	___	___
Menthol Cough Drops .....	___	___
Benadryl .....	___	___

May we have permission to use:	Yes	No
Antibiotic Ointment .....	___	___
Calamine Lotion .....	___	___
Antiseptic Cream .....	___	___
Hydrocortisone Cream .....	___	___
Orajel (for dental pain) .....	___	___

Would you like to be notified BEFORE \_\_\_ AFTER \_\_\_ or NOT NECESSARY \_\_\_ if we administer medication at school?

Should Compass Classical Academy be aware of any other medical problems or restrictions?

The State of New Hampshire requires parental permission and a doctor's order for students who need an Epi-Pen, Inhaler or prescription medications while in school.

Doctor's Name \_\_\_\_\_

Phone \_\_\_\_\_

Dentist's Name \_\_\_\_\_

Phone \_\_\_\_\_

### Permission to provide Emergency Treatment

I Hereby grant to Compass Classical Academy to administer First Aid, Epinephrine (Epi-Pen), if necessary, and secure proper emergency treatment for my child in the event a parent or legal guardian cannot be contacted.

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

Date \_\_\_\_\_

### Permission to contact student's doctor.

To confirm immunization and physical examination during the school year (August to June).

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

Date \_\_\_\_\_

### Permission to notify the appropriate staff of necessary student health concerns.

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

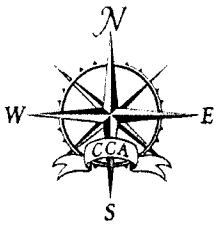
Date \_\_\_\_\_

I have confirmed all of the above information concerning my child and will notify Compass Classical Academy immediately of any changes.

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

Date \_\_\_\_\_





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## Prescription Medication Order and Permission Form To be forwarded to the school nurse.

### To be filled out by parent/guardian:

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

I hereby give my permission to my son or daughter's physician/nurse practitioner  
\_\_\_\_\_ to release information to Compass Classical Academy concerning  
medication(s) prescribed for my son or daughter, \_\_\_\_\_, Date of Birth  
\_\_\_\_\_ and for my above named son or daughter to take the medication as prescribed at  
school. I will notify the school nurse if there are any changes in medication time or dosage, or if the medication  
is stopped.

Signature of Parent or Guardian \_\_\_\_\_



### To be filled out by healthcare provider:

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Directions \_\_\_\_\_

Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_

Reason for giving \_\_\_\_\_

Signature of healthcare provider \_\_\_\_\_

Phone number of healthcare provider \_\_\_\_\_ Fax \_\_\_\_\_



### To be signed by parent/guardian and healthcare provider (For rescue inhalers, Epi-Pens and diabetic supplies only):

I hereby give permission for (name of student) \_\_\_\_\_ to carry  
his/her own (name of medication \_\_\_\_\_) for his/her

(circle one) Asthma      Diabetes Mellitus      Allergy

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

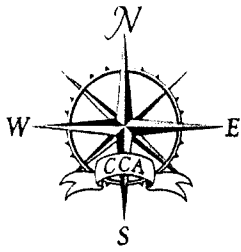
Signature of healthcare provider \_\_\_\_\_



No medication will be given at school until the school receives this completed form with the prescribed medication in a container appropriately labeled by the pharmacy or physician.

All medication brought to school, with the exception of rescue inhalers, Epi-Pens, or diabetes supplies, must be kept in the Health Office.





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## RESIDENCY AFFIDAVIT AND AGREEMENT

I attest that I am the legal guardian of the child /children listed below:

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

and that I and the above named child / children are legal residents of and reside in the Town of \_\_\_\_\_

Our physical address is: \_\_\_\_\_

I have been residing at this address since \_\_\_\_\_, I intend that I shall continue as a resident of that town during the 2016-2017 school year.

I agree that, immediately upon any change in my residency or the residency of my child / children, I shall inform the Director of Compass Classical Academy.

The facts set forth in this residency affidavit are true and complete. I understand that providing misleading or false information about residency is a criminal offense.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

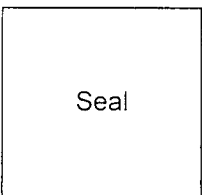
\_\_\_\_\_  
Signature

STATE OF NEW HAMPSHIRE

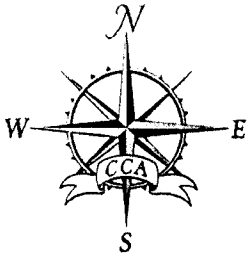
COUNTY OF \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_, personally appeared the above-named is subscribed to the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

Before me,



\_\_\_\_\_  
Notary Public / Justice of the Peace



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## REQUEST FOR RECORDS

As the legal parent or guardian of \_\_\_\_\_, I hereby authorize the release of **all educational school records** for the purpose of enrollment in Compass Classical Academy.

Records to be sent to: Compass Classical Academy  
A Public Charter School  
570 W. Main St.  
Tilton, NH 03276

Attn: Judy Tilton

Type of information to be released:

**Records including, but not limited to:**

- **Discipline Records**
- **Academic Files**
- **Report Cards**
- **Progress Notes**
- **Medical Record**
  - **Special Education Records if applicable**
  - **IEP**
  - **Psychological Reports**
  - **Psycho-educational testing – Speech and Language Evaluation – Occupational Therapy Evaluations, Academic Testing**
  - **Psycho-Social Evaluations**

Records requested from: School Name \_\_\_\_\_

Address \_\_\_\_\_

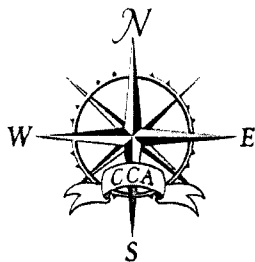
Phone \_\_\_\_\_

Fax \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent or Guardian



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## The Extended Day Program: A useful and enjoyable option for your child

Are you interested in enrolling your Compass Classical Academy student in an Extended Day Program? We have a flexible option for your daily needs.

Our staff will be operating an Extended Day Program starting with the first day of school and for each day of school through the end of the school year. This after school program will include a homework club (an opportunity to work on and get help on homework) and also an opportunity to get exercise (outdoors weather permitting).

The morning program will run from 7:00 AM – 7:45 AM, and the after school program will run from 3:15 PM to 5:30 PM each day that school is held.

We have kept the cost low because our purpose is to offer convenience to our parents and to provide a fun and safe place for your children to spend their nonschool hours when you are unable to be there.

Thank You,  
Compass Classical Academy



**Cost:**

AM Program (7:00 AM – 7:45 AM)	\$5 per child per day
PM Program (3:15 PM – 5:30 PM)	\$10 per child per day
Both AM and PM	\$70 per child per week

Please make checks out to Compass Classical Academy at the end of each week.

I am interested in enrolling my child in the AM program.

I am interested in enrolling my child in the PM program.

I am interested in enrolling my child in both programs.

Student's Name \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_

Please return this form to Compass Classical Academy as soon as possible and prior to the first day you desire to have your child take part in this program.

