



Your district's tuition-free  
online K-12 school

# Teays Valley Local Schools

## Digital Academy

385 Viking Way  
Ashville, OH 43103  
Director Joel Baker Phone:  
(740) 983-5002 Fax: (740) 983-5035



### 2018-19 Teays Valley Digital Academy Application

Teays Valley Digital Academy is an alternative educational option utilizing online curriculum and local staff support for students who seek a non-traditional learning experience. All applicants will be contacted for a scheduled interview with the program director / Guidance Counselor. Please Note: Enrollment is not guaranteed based solely on submission of application

Student's Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Middle Last Month/ Day/ Year

Address: \_\_\_\_\_ Student Cell # \_\_\_\_\_  
House # Street Name City, State Zip

Gender: \_\_\_\_\_ Current School \_\_\_\_\_ Grade Level 2017-18 \_\_\_\_\_ Student ID \_\_\_\_\_

Parents / Guardian Name (s) \_\_\_\_\_ Telephone: \_\_\_\_\_

Is the student currently, or has the student been, suspended/expelled from school during the current or previous school term \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Is student enrolled in a special education program or a 504 plan: \_\_\_\_\_

Do you have access to high speed internet / computers in your home: \_\_\_\_\_ Do you have transportation: \_\_\_\_\_

- Check the box that explains your enrollment status:   New applicant   
 District resident enrolled at Teays Valley   
 Current open enrollment to Teays Valley   
 Current student moving out of Teays Valley District

Check the box that explain reason for enrollment:   Medical   Credit Recovery   Elective Credits   Other

What courses would you like to take: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By signing this application I am requesting that my child be considered for enrollment in to the Teays Valley Digital Academy during the 2018- 19 school year/term. I have read and understand the policies and guidelines which govern the program. Providing inaccurate information on this application will void consideration of your request. Those closest to graduation will be given first consideration.

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

# TEAYS VALLEY LOCAL SCHOOL DISTRICT

385 Viking Way, Ashville, Ohio 43103-9417

Phone: 740-983-5000 Fax: 740-983-4158

[www.tvsd.us](http://www.tvsd.us)

Robin Halley, Superintendent

Kyle Wolfe, Assistant Superintendent

Stacy Overly, Treasurer

## Teays Valley Digital Academy Student / Parent Contract.

Students (and their parents/guardians) understand that signing this contract is required to enroll in Teays Valley Digital Academy. Students (and their parents/guardians) agree to commit to the completion of all courses that the student is enrolled in through the Digital Academy. Students (and their parents/guardians) understand that all fees associated with enrollment in the Digital Academy will be paid for by Teays Valley School District, unless the student is removed from the program for failure to complete the course in the allowed time or dismissal from the program for disciplinary reasons. Students (and their parents/guardians) understand in the event that a student is removed from the program the parents/guardians will be responsible for all fees associated with the program. If a student is removed from the program they may not reapply until the following school year.

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

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Parent/Guardian's Name \_\_\_\_\_

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

**EMERGENCY MEDICAL AUTHORIZATION FORM**  
**School Term 2017-2018**

**NOTIFY THE SCHOOL OF ANY CHANGE IN PHONE OR EMERGENCY NUMBERS**

School \_\_\_\_\_ Grade \_\_\_\_\_

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

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Primary Phone # \_\_\_\_\_

Secondary Phone # \_\_\_\_\_

**The following is required by Section 3313.712 of the Ohio Revised Code.**

**Purpose** – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

**Residential Parent or Guardian:**

Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

**Name of Relative or Childcare Provider** \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**PART I OR II MUST BE COMPLETED**

**PART I - (To Grant Consent)**

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

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Local Hospital \_\_\_\_\_ Emergency Room Phone \_\_\_\_\_

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 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 of 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 a physician should be alerted:**

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

Address \_\_\_\_\_

**PART II – (REFUSAL TO GRANT 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:

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

Address \_\_\_\_\_

**Teays Valley Digital Academy**  
**Parent/Guardian Contact Form**

Student Last Name:	
Student First Name:	
Guidance Counselor:	
Parent / Guardian Name(s):	Street Address:
1.	
2.	
3.	
4.	
Home Phone: (      )	
Cell Phone: (      )	
Work Phone: (      )	
Student Cell: (      )	
Email Address(s):	
1.	
2.	
Preferred Method of Communication:	
Phone Call: ____      Email: ____      Note home with student: ____	
Preferred Time for Communication:	
Morning: ____      Afternoon: ____      Evening: ____	
Interpreter / Translation needed?    Yes ____      No ____	

**Teays Valley Digital Academy**  
**Parent/Guardian Contact Form**

**FOR OFFICE USE ONLY: DO NOT WRITE IN THIS AREA**

Date Application Received: \_\_\_\_\_

Approved  Denied

Reason if denied: \_\_\_\_\_

Effective Date for enrollment \_\_\_\_\_

Student's Guidance Counselor: \_\_\_\_\_

Periods Attending:

Full Time

1st  2nd  3rd  5th  6th  7th  8th  9th

Building Principal Signature: \_\_\_\_\_

Guidance Signature: \_\_\_\_\_

\*No student shall be denied admission to the Teays Valley Digital Academy or discriminated against for reasons of race, color, national origin, sex, handicap or any other basis of unlawful discrimination. However, the district has the right to set classroom capacity limits.