

Online Course Application

School Year _____

Fall

Spring

Summer

PLEASE PRINT CLEARLY

Student Information

First Name: _____	Last Name: _____	
Student ID #: _____	Home School: _____	Grade: _____
Current Address: _____	Apt. # _____	
City: _____	State: _____	Zip: _____
Phone: _____	Email: _____	

Parent/Guardian Information

First Name: _____	Last Name: _____
Daytime Phone: _____	Email: _____

Information to be filled out by school counselor:

Online Course Name: _____			
ASD Course #: _____	Sem. 1 <input type="checkbox"/>	Sem. 2 <input type="checkbox"/>	
This student has:	An IEP <input type="checkbox"/>	A 504 <input type="checkbox"/>	Neither an IEP nor 504 <input type="checkbox"/>
Has payment be received?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Waived <input type="checkbox"/>
Date of payment: _____	If waived, by whom: _____		

Completion of this form does not guarantee enrollment in an ASD online course. Student participation requires meeting eligibility requirements, paying applicable course fees, authorization of a parent/guardian and a school administrator, and depends on course availability. I have read and understand the "ASD Guidelines for a Successful Online Student" and agree to work at the pace established by my online instructor when the course begins. I understand that it is my responsibility to communicate concerns about coursework or accessibility issues with my instructor in a timely manner.

Student's Signature

Parent/Guardian's Signature

Counselor's Signature

Curriculum Principal's Signature

**PLEASE COMPLETE ALL OF THE ABOVE INFORMATION AND FAX TO THE ONLINE OFFICE AT 742-1174.
FOR QUESTIONS, CONTACT MARY RIORDAN AT 742-1170 OR EMAIL RIORDAN_MARY@ASDK12.ORG.**

APEXOC <input type="checkbox"/>	LOC <input type="checkbox"/>	MDL <input type="checkbox"/>	ECODE: _____	START: _____
UN: _____	PW: _____	EMAILED: _____		