SOUTHERN LOCAL SCHOOL DISTRICT
REQUIRED PARENT SIGNATURE PACKET
2022-23

Handbooks and other school information can be found on our website: *southernlocalmeigs.org*

Student Name: ________________________ Gr.: _____ Homeroom Teacher: ______________________

revised 8/22

PARENT OR GUARDIAN INTERNET AGREEMENT

To be read and signed by parents or guardians of students who are under age 18:

As the parent or legal guardian of the above student I have read, understand, and agree that my child or ward shall comply with the terms of the School District's Acceptable Use and Internet Safety Policy for the student's access to the school district's computer network and the internet. I understand that access is being provided to the students for educational purposes only. However, I understand that it is impossible for the school to restrict access to all offensive and controversial materials and understand my child's or ward's responsibility for abiding by the policy. I am therefore signing this policy and agree to indemnity and hold harmless the school, the district and the data acquisition site that provides the opportunity to the school district for computer network and internet access against all claims, damages, losses and costs, of whatever kind, that may result from my child's or ward's use of his/her access to such networks or his/her violation of the foregoing policy. Further, I accept full responsibility for the supervision of my child's or ward's use of his/her access account if and when such access is not in the school setting.

Please sign on the appropriate page of this packet (page 13) to give permission for your child or ward to use the building-approved account to access the school district's computer network and the internet.

STUDENT'S AGREEMENT

I have read, understand and agree to abide by the terms of the foregoing Acceptable Use and Internet Safety Policy. Should I commit any violation or in any way misuse my access to the school district's computer network and the internet, By signing on page 13, I understand and agree that my access privilege may be revoked and school disciplinary action may be taken against me.

Legal References: **Children's Internet Protection Act of 2000 (HR 4566, PL 106-554**
Communications Act of 1934, as amended (47 USC 254(h), (1)
Elementary and Secondary Education Act of 1965, as amended (20US 6801 et seq., Part F

Student Name: ___________________________ Gr.: ____ Homeroom Teacher: ________________________

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EMERGENCY EVACUATION

State law requires schools have in place an emergency evacuation procedure. In the event of an emergency evacuation from Southern Local School, ALL students will go to the Racine Baptist Church. Parents are advised to **NOT PICK UP** their children unless they do so on a regular basis. **You will receive an automated call, text, and/or email if we have an emergency evacuation. By completing the following form, you are directing the school as to your wishes concerning your child. Parents are to have a plan of action once the child arrives home (go to a neighbor, call a relative, etc.)**

Student's Name: ______________________ Homeroom: ________________

Persons having legal custody: ___________________________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: _______________

Please check ONE of the following:

_____ My child is ALWAYS to go home on the bus for Emergency Evacuations. Bus # ___ Driver________

_____ My child is a walker. I understand that he/she will be excused from the Racine Baptist Church to walk home.

_____ My child will be picked up from the Racine Baptist Church by one of the people on the Pick-Up Permission form at the bottom of this page. I understand that it is my (parent) responsibility to notify them as soon as I receive the automated call.

Student Pick-up Permission

A child may go home only with those whose names are in the files. If anyone not on this list comes to pick up your child, we will **NOT** allow him/her to go without a note from you. One copy will be kept in the office and the teacher (grades Prek-6) will keep a copy.

My child, __________________________ has permission to be picked up **ONLY** by the following persons:

1.__________________________ 2.__________________________ 3. __________________________

4.__________________________ 5.__________________________ 6.__________________________

I understand that if I send someone other than those listed above, I will send a note to school with that person and call the school ahead of time to make them aware of this.

Student Pick-up Restrictions

My child under no circumstances is to be picked up by: *Please be advised that if you are restricting a biological parent, we must be provided with a court order so we can abide by this restriction.*

1.________________________ 2.__________________________ 3.__________________________

Signature of Parent or Legal Guardian: ____ **Date:** ____________

Student Name: ______________________ Gr.: ____ Homeroom Teacher: ______________________

revised 8/22

Southern Local Schools

920 Elm Street. Racine, Ohio 45771

EMERGENCY CONTACT and MEDICAL FIRST AID AUTHORIZATION and CONSENT

Child's Name ______________________ Date of Birth ______________ SS# ______________

Home Address ______________________ Telephone ______________ Male *or* Female

Instructions to reach PARENT/GUARDIAN (daytime):

Parent/Guardian Name: ______________________
Relationship to Child: ______________________
Home Address: ______________________
Home Telephone: ______________________
Cell Phone: ______________________
Work Phone: ______________________

Parent/Guardian Name: ______________________
Relationship to Child: ______________________
Home Address: ______________________
Home Telephone: ______________________
Cell Phone: ______________________
Work Phone: ______________________

Email contact ____

EMERGENCY CONTACT PERSONS In the event parents/guardians cannot be contacted, I hereby give *Southern Local Schools* my permission for my child (name) ______________________, to be released to the following: (Please list 4 contacts)

Name : ______________________
Relationship to Child : ______________________
Address: ______________________
Telephone (day): ______________________
Cell Phone: ______________________
Email: ______________________

Name : ______________________
Relationship to Child: ______________________
Address: ______________________
Telephone (day): ______________________
Cell Phone: ______________________
Email: ______________________

Name : ______________________
Relationship to Child : ______________________
Address: ______________________
Telephone (day): ______________________
Cell Phone: ______________________
Email: ______________________

Name : ______________________
Relationship to Child: ______________________
Address: ______________________
Telephone (day): ______________________
Cell Phone: ______________________
Email: ______________________

Physician Name: ______________________
Physician Address : ______________________
Physician Phone number: ______________________

Dentist Name: ______________________
Dentist Address: ______________________
Dentist Phone number: ______________________

HEALTH INSURANCE INFORMATION

Insurance Company: ______________________
Subscriber Name: ______________________
Policy #: ______________ Card#: ______________
Authorized Hospital: ______________________

DENTAL INSURANCE INFORMATION

Insurance Company ______________________
Subscriber Name: ______________________
Policy #: ______________ Card#: ______________
Authorized Hospital: ______________________

If you would like the wellness center to give your child over the counter medication, please provide the medication in the original container marked with the child's name and homeroom teacher.

___ Yes ___ No I give the Wellness Center with signed consent or the school nurse permission to give my child Tylenol, Motrin, Tums, and/or cough drops as needed.

Parent/Guardian Signature: ______________________ **Date:** ______________

Please Complete back of form

Student Name: ______________________ Gr.: _____ Homeroom Teacher: ____________________

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Please list the child's siblings that attend Southern Local ______________________________

---Does your student have an allergy to any medications, foods, insects, latex or other substances? ☐ **Yes** ☐ **No**
If **Yes**, please list in detail: ______________________________

Please circle if allergy is **severe** **moderate** **mild**
List symptoms: ______________________________

What medication(s) or treatment is used to treat the allergy? ______________________

____

Has your child ever had a severe "anaphylactic" reaction requiring emergency care (list date)?

____

If your student is on medication, please list medication, dosage, frequency and reason for medication: ______________________________

Please note any concerns of which the school nurse needs to be aware:

____

Please check all that apply to your student:

- ☐ Allergies-seasonal
- ☐ ADHD
- ☐ Asthma
- ☐ Chicken Pox - Date:__________
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Dyslexia/Learning Disorder
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Epilepsy/Seizure Disorder
- ☐ Heart Condition
- ☐ Hearing Problems
- ☐ Kidney Disorder
- ☐ Migraine Headache
- ☐ Muscular/Orthopedic Disorder
- ☐ Psychiatric Psychological Disorder
- ☐ Serious Accident
- ☐ Surgery
- ☐ Vision Problems
- ☐ Other: __________

MEDICAL EMERGENCY TREATMENT AUTHORIZATION

I authorize staff members at *Southern Local Schools* **who are trained in the basics of first aid and CPR to administer aid and/or CPR to my child (name) ______________________, when appropriate.**

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child (name) ______________________.

In the event of an emergency requiring medical attention for my child, if I cannot be reached or when delay would be dangerous to my child's health, I hereby authorize *Southern Local Schools* **to transport my child (name) ______________________ to the nearest medical facility and/or Hospital. I hereby authorize Southern Local Schools to secure for my child the necessary medical treatment.**

Parent/Guardian Signature: ______________________ **Date:** ______________

Student Name: ____________________ Gr.: ____ Homeroom Teacher: ____________________

revised 8/22

Southern Local School District

2022-23

Dear Parents, Grandparents, and Guardians,

Most of us think education is important, that is why we need your help. You can help by being a **VOLUNTEER! VOLUNTEERING** will benefit your child. They will know you are in the school and that education is important to you.

SOUTHERN LOCAL SCHOOL DISTRICT VOLUNTEER APPLICATION FORM

Please Complete All Areas That Apply

Name:____________________ E-Mail Address: ________________ Languages: ____________

Phone:________________ Have You Volunteered Before? ____ Yes ____ No

Volunteer Area Preferred (Please Check All That You Are Interested In)

_____ Chaperone _____ Room Parent _____ Special Speaker

_____ Fall Carnival _____ Classroom Helper _____ PTO

______ Concession stand at games

_____ Special Projects: (Right to Read, Red Ribbon Week, Book Fair, Santa's Workshop)

_____ Other (Specify): Please specify other ways in which you would like to volunteer.

Grade level(s) Desired ______________ **Days and Times Available**____________________

Child(ren) Enrolled ____

_____ **I have not been convicted of a felony or any crime involving a child.**

_____ **I agree to perform volunteer services and uphold all procedures as prescribed by the School District.**

______________________________ ______________

Signature Date

Note: Your application will not be processed without a signature.

OFFICE USE ONLY DO NOT WRITE BELOW THIS LINE

Name:____________________Address:____________________Phone:__________

( ) Principal Approval ( ) Principal Disapproval ( ) Superintendent Approval ( ) Superintendent Disapproval

______________________________ __________

(Principal's Signature) Date

______________________________ __________

(Superintendent's Signature) Date

Student Name: ______________________ Gr.: _____ Homeroom Teacher: ____________________

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Southern Local SD
920 Elm Street Racine, OH 45771 (740) 444-4325

HOUSEHOLD INFORMATION SURVEY

Southern Local will participate in the Community Eligibility Provision (CEP) under the National School Lunch Program (NSLP). Under this option, all children in the school receive a breakfast/lunch at no charge regardless if they complete this form. **However, to determine eligibility for various additional state and federal program benefits that your child's school may qualify for, please complete, sign and return this application to your school building if your income falls within or below the guidelines listed in the following chart.**

INCOME GUIDELINES – 185%

Guidelines to be effective from July 1, 2022 through June 30, 2023

INCOME ELIGIBILITY GUIDELINES 2022-2023			
Household size	Yearly	Monthly	Weekly
1	$25,142	$2,096	$484
2	33,874	2,823	652
3	42,606	3,551	820
4	51,338	4,279	988
5	60,070	5,006	1,156
6	68,802	5,734	1,324
7	77,534	6,462	1,492
8	86,266	7,189	1,659
Each Additional Person:	8,732	728	168

If any member of your household receives Supplemental Nutrition Assistance Program (SNAP) (formerly food stamps) or Ohio Works First (OWF) benefits, provide the name and 7 or 10-digit case number for the person who receives the benefits then proceed to Section 4. If no one receives these benefits, start with Section 1.

Name: ______________________ 7 or 10-digit Case Number: ______________________

INSTRUCTIONS: Complete this survey and return to your child's school or mail to the following address:
Southern Local SD C/O Tim Thoren, 920 Elm Street, Racine, OH 45771.
The following selections must be completed by the Head of Household or Designee:

1. **SIZE OF FAMILY** - Indicate the total number of individuals living in your household, including all adults and children: ________
2. **STUDENT INFORMATION** - Complete for each student Pre-K through grade 12.

Last Name	First Name	Birth Date MM-DD-YY	School	Identify: H = Homeless M = Migrant R = Runaway F = Foster
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

For additional lines, please attach a second sheet to this survey or attach a copy of this survey clearly marked as Page 2.

Student Name: ______________________ Gr.: _____ Homeroom Teacher: ______________________

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3. **TOTAL MONTHLY HOUSEHOLD INCOME** – Report income for all members of household excluding foster children. If you have reported a case number above, please do not complete this section. Proceed to section 4.

Type of Income	Income	Circle if No Income
1. Gross Monthly Earnings: Wages, Salary, Commissions	$	None
2. Monthly Welfare Payments, Child Support, Alimony	$	None
3. Monthly Payments from Pensions, Retirement, Social Security	$	None
4. Monthly Dividends or Interest on Savings	$	None
5. Monthly Worker's Compensation, Unemployment, Strike Benefit	$	None
6. Other Monthly Income (SSI, VA, Disability, Farm, other)	$	None
Total Monthly Household Income (Add lines 1-6)	$	

4. **SIGNATURE** - If income section is completed, the adult signing the form must also list the last four (4) digits of his or her Social Security number or check the "I do not have a Social Security number" box below.

I certify (promise) that all information on this application is true and that all income is reported. I understand the school will be eligible for certain federal and/or state funds based on the information I give. I understand that the school officials may verify (check) the information. I understand that if I purposely give false information, my child may lose benefits and I may be prosecuted.

Sign Here: X______________________ Print Name:______________________

Date______________

Last Four (4) Digits of Social Security Number: XXX-XX- ________ ☐ I do not have a Social Security Number

Address	City	Zip Code

Home Phone	Work Phone	Email Address
		By providing your email address, you may be contact via email by the district.

For Internal Office Use Only:

Please circle one option.

QUALIFIES DOES NOT QUALIFY

Student Name: ______________________________ Gr.: _____ Homeroom Teacher: __________________________

revised 8/22

Southern Local Title 1 906 Elm Street. Racine, Ohio 45771
SCHOOL/PARENT COMPACT

The purpose of Southern Local's Title I **SCHOOL/PARENT COMPACT** is to build and to foster the development of a school-parent partnership to help all children achieve the state's high standards. **The parents, the child, the school, and the teachers will share responsibility for improved student achievement.**

COMMITMENT FROM SOUTHERN LOCAL:

We support this form of parent involvement. Therefore, Southern Local School District will strive to do the following:

1. Provide high-quality curriculum and instruction in a supportive and effective learning environment that enables our students to meet Ohio's academic content standards and is taught by staff that meets Highly Qualified Standards.
2. Hold parent-teacher conferences during which this compact will be discussed as it relates to the individual student's achievement.
3. Provide parents with frequent reports on their child's progress through interim and nine-week grade reports.
4. Provide parents reasonable access to staff.
5. Provide parents opportunities to volunteer and to participate in their child's class, and to observe classroom activities with parent involvement and family activity nights.
6. Involve parents in the planning, review and improvement of the school's parental involvement policy and involve parents in the development of any school wide program plan.

COMMITMENT FROM STAFF/TEACHER

I agree to be responsible in the following ways:

- Provide a high quality curriculum that enables the child to meet state performance standards.
- Notify parents of changes affecting attendance, achievement, grades, or behavior.
- Provide open communications between parents and teachers.
- Provide opportunities for parents to volunteer, to participate, and/or to observe in my class.
- Participate in conferences.
- Report children's progress.
- Be available to staff and parents.
- Other____________________

Signature of Classroom Teacher ________________________________ **Date** __________

COMMITMENT FROM PARENT/GUARDIAN

As a parent or adult who has responsibility for the child, I will attend at least one parent-teacher conference during which this compact relates to my child's achievement. I will read each progress report and talk to my child about the progress report. I understand that I will have reasonable access to my child's teachers along with opportunities to volunteer, to participate in my child's class, and to observe classroom activities.

I agree to be responsible for supporting the learning of my child. Examples of ways I can help my child include:

- Establishing a time for homework
- Participating in conferences
- Establishing a place for study
- Monitoring attendance
- Ensuring that homework is completed
- Reading progress reports
- Discussing progress reports
- Assisting my child in learning to resolve conflicts in positive ways
- Supporting the school in its efforts to maintain proper discipline
- Monitoring television time
- Respecting all school staff and the cultural differences of others
- Promoting positive use of my child's extracurricular time
- Checking for home/school communication
- Other: ____________________________

Signature of Parent/Guardian: ________________________________ **Date**__________

COMMITMENT FROM STUDENT

I agree to be responsible for improving my achievement in the following ways:

- Attending school regularly
- Asking for help when I need it
- Coming to class prepared
- Completing homework every day
- Listening and participating in class
- Sleeping 8-10 hours each night
- Eating a nutritious breakfast
- Giving my parents communications from school
- Supporting and abiding by all school rules and codes of conduct
- Respecting and cooperating with other students and adults
- Reading at least 15-minutes every day outside of school
- Other: ____________________________

Signature of Student ________________________________ **Date** __________

Student Name: ______________________ Gr.: _____ Homeroom Teacher: ______________________

revised 8/22

PARENT OR GUARDIAN INTERNET AGREEMENT

I am acknowledging that my child or ward will need to use the building-approved account to access the school district's computer network and the internet.

PARENTAL AND STUDENT UNDERSTANDING OF STUDENT HANDBOOK

________ I have read the student handbook and understand the policies and procedures outlined within.

WALKING FIELD TRIPS

From time to time students will be going on walking field trips. If a teacher is going to take a class on a special trip, they will send home permission slips.

_____My child DOES HAVE permission to go on walking trips.

OR

_____My child DOES NOT HAVE permission to go on walking field trips.

PHOTO/VIDEO CONSENT

As a parent or guardian of this student, I hereby consent to the use of photographs/videotape taken during the course of the school year for publicity, promotional, and/or educational purposes (including publications, presentation or broadcast via newspaper, internet or other media sources). I do this full knowledge and consent for use, or for damages.

___Yes, I give consent for Southern Local Schools to photograph/video my child in regard to the above statement for school purposes and/or at school events.

___ No, I do NOT authorize Southern Local Schools to photograph/video my child for any event.

STUDENT'S INTERNET AGREEMENT

_______I have read, understand and agree to abide by the terms of the foregoing Acceptable Use and Internet Safety Policy. Should I commit any violation or in any way misuse my access to the school district's computer network and the interne. By signing below, I understand and agree that my access privilege may be revoked and school disciplinary action may be taken against me.

Parent Signature ______________________________ **Date** ________________

Student's signature ______________________________ **Date** ________________

PARENT PERMISSION FOR THE DISTRICT TO COMMUNICATE ABOUT A STUDENT WITH THE PARENT VIA FACSIMILE (FAX) AND/OR E-MAIL

Parent's Name: ____________________

Parent's E-mail Address: ____________________________ Parent's Facsimile (fax) Number: ___________

I give permission for staff members from the Southern Local School District to communicate with me, concerning the above identified student, via e-mail and/or facsimile at the e-mail address and/or facsimile number provided above. I understand that the District is unable to guarantee the confidentiality of any information sent using e-mail or facsimile during the transmission of the message/fax. I further agree that I am the only one with access to the e-mail account and/or facsimile number listed above, and that if other individuals have access to the e-mail address and/or facsimile number listed above, that I hereby release the District from any responsibility and liability for any disclosure of student personally identifiable information to anyone who accesses the e-mail address and/or facsimile number listed above. I further acknowledge it is my responsibility to notify the District of any changes in the e-mail address and facsimile number listed above. Finally, I agree to promptly respond to any "test" e-mail message sent from the District to my e-mail address to confirm that the address provided has been properly inputted into the District's/staff member's address book. This permission form is for the 2022-23 school year. It will remain valid until the District receives written direction from the parent to the contrary, or the present school year ends.

Parent's signature______________________________ **Date**______________

Student Name: ____________________ Gr.: _____ Homeroom Teacher: ____________________

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School Based Health Enrollment Form

PATIENT INFORMATION *

Student/Patient Name: ____________________ Student SS #: ____________________
Street Address: ____________________ City: ____________________
State/Zip: ____________________ Email: ____________ School: __________
Phone: __________ Cell: __________ Grade: ________ Date of Birth: __________
Gender (circle one): Female, Male, Transgender Male, Transgender Female, Other, Chose not to disclose
Sexual Orientation (circle one): Straight, Lesbian/Gay, Bisexual, Other, Don't know, Chose not to disclose
Race: *White, Black, Hispanic or Other if so list:* ____________________

PARENT / GUARDIAN INFORMATION

Father: ____________________ (email) ____________________
Phone (H) ______________ (W) ______________ (C) ______________
Mother: ______________ Maiden Name: __________ (email) ______________
Phone (H) ______________ (W) ______________ (C) ______________
Guardian: ____________________ (email) ____________________
Phone (H) ______________ (W) ______________ (C) ______________

EMERGENCY /ALTERNATE CONTACT INFORMATION: I understand that by providing an alternate contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact (including all relevant information with exception to psychiatric/mental health, alcohol/drugs and HIV / AIDS information).

Name: ____________________ Relationship: __________ May we leave a message? __ Y __ N
Phone: (Home) ______________ (Work) ______________ (Cell) ______________

Health Information *(Additional health, family & developmental history may be collected if seen at the clinic.)*

1. Doctor's name: ____________________ Date of last well child exam: __________
2. If your child has not seen a doctor within the last year, would you like your child to have a well child exam at our wellness center? **Yes or No**
3. If we need to call in a prescription, which pharmacy would you like us to call? ____________________

CURRENT MEDICATIONS		
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:
Medication:	Dose (mg):	Directions:

ALLERGIES	
Allergen:	Reaction:
Allergen:	Reaction:
Allergen:	Reaction:
Allergen:	Reaction:
Allergen:	Reaction:

Does the child have an order for and carry any of the follow: (Check all that apply)

_____ Epi Pen _____ Insulin _____ Glucagon

Parent/Guardian Initials: _____

Student Name: ____________________ Gr.: _____ Homeroom Teacher: ____________________

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Student/Patient Name:____________________ Date of Birth:____________

MEDICAL HISTORY List chronic or intermittent disease or health problem(s). Ex: Diabetes, Asthma, High Blood Pressure

____

____

SURGERIES List the type and date of the operation (example: tonsils – September 2010)

____

SERIOUS INJURY OR ACCIDENTS List type of accident and resulting injury and the date (example: broken right leg, 10/08)

____

Portable Dental Unit

The portable dental unit visits schools twice a year (fall and spring) for dental exams, fluoride treatments, cleaning and sealants. **Please note if your child has an appointment and the forms are not signed and returned for each dental visit, the appointment will be cancelled. If your child is going to another dentist and does not need these services, please mark "no" below.**

Services utilized through the Portable Dental Unit will be billed to your insurance. You will NOT be responsible for any portion of the bill not paid by your insurance. If you do not have coverage, a flat fee of $20.00 is charged for your child to be seen by the dentist. To qualify for this reduced rate, you must complete the income section of the enrollment and consent form.

If your child already has a dentist, he/she does not qualify for this program. Your insurance will not cover the fees of both your regular dentist *and* this program.

Name of Current Dentist:____________________ Date of last dental exam: ____________

If your child has not seen a dentist in the last year, would you like your child to have a dental cleaning at our Wellness Center? **Yes** or **No** If yes, do you want your child to have dental sealants on the same day as cleaning? **Yes** or **No**

If you selected to have your child receive cleanings and/or sealants, signing this enrollment form will provide consent for him/her to participate in the portable dental services and confirms that your child does not already have a dentist.

INSURANCE INFORMATION – Please complete all that apply. **Please provide a copy of front and back of card.

- ☐ **Primary Health Insurance:** Name of Insured Parent / Guardian____________________
  - Date of Birth of Card Holder____________ SSN of Card Holder ____________
  - Address (if different from child):____________________
  - Place of Employment ____________________
  - Name of Insurance Company ____________________
  - ID Number ____________________
  - Group Number ____________________
- ☐ **Secondary Health Insurance:** Name of Insured Parent / Guardian____________________
  - Date of Birth of Card Holder____________ SSN of Card Holder ____________
  - Address (if different from child):____________________
  - Place of Employment ____________________
  - Name of Insurance Company ____________________
  - ID Number ____________________
  - Group Number ____________________
- ☐ **Dental Insurance:** Name of Insured Parent/Guardian:____________________
  - Date of Birth of Card Holder____________ SSN of Card Holder ____________
  - Address (if different from child):____________________
  - Place of Employment ____________________
  - Name of Insurance Company ____________________
  - ID Number ____________________
  - Group Number ____________________
- ☐ **No health insurance / Request application for sliding fee**
  - ○ **I would like assistance from Coplin Health Systems to obtain insurance**

Parent/Guardian Initials: ______

Student Name: ______________________ Gr.: _____ Homeroom Teacher: ______________________

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Student/Patient Name:______________________ Date of Birth:____________

INCOME INFORMATION – Please complete all that apply. Please Circle the Following:

How many people are currently living in your household? 1 2 3 4 5 6 7 8 9
What is your estimated household monthly net income?
$100–500 $501-$1000 $1001 –$1500 $1501-$2000 $2001-$2500 $2501-$3000
$3001-$3500 $3501-$4000 $4001-$4500 $4501-$5000 $5001-$5500 $5501- $6000
My child qualifies for free or reduced lunch: Yes or No

Sliding Scale Fee Information

Even if you have health insurance, this program may help you with the cost of health care at our facility. This program is offered through Coplin Health Systems and may pay a portion of the costs for office visits. Families with insurance may qualify for deductible and co-pay discounts. Documentation required includes a Jackson County Schools Wellness Center enrollment and consent form, a completed sliding fee scale application with proof of total family income, and a copy of the two most recent check stubs for each person living in the household.

CONSENT FOR SBHC (School Based Health Center) SERVICES

I, the parent/guardian, with my signature of this form, give consent for my child to receive services at Coplin Health Systems' School-Based Wellness Center. I understand that this consent form will be good for one year or until I provide Coplin Health Systems with written directions otherwise, whichever is shorter. All healthcare information is confidential. By signing the consent form you are giving Coplin Health Systems, school nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes. Confidentiality between the student, parents and the health center is assured. I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

HIPAA OF 1996 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all health care providers and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed as well as how a patient may obtain access to their personal health information. This notice can be found on our website at www.coplinhealth.com or by requesting a copy from Coplin Health Systems' staff. Your signature of this form certifies that you have reviewed the Notice of Privacy Practices. The notice of privacy practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of bills, or in the performance of Coplin Health Systems' care operational and other purposes that are permitted and required by law. It also describes my rights to access and control of my protected health care information. The Notice of Privacy Practices is also posted in the waiting areas.

PARENT/GUARDIAN SIGNATURE

The information I have given is correct to the best of my knowledge. I understand that my medical information and/or that of my child will remain confidential and it is my responsibility to inform the Wellness Center staff of any changes in medical care and status.

______________________________ ______________
Signature of Parent / Legal Guardian Date

Printed Name of Parent/Guardian ______________________________

Parent/Guardian Initials: ______

Student Name: ____________________________ Gr.: _____ Homeroom Teacher: ________________________

revised 8/22

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It is the responsibility of each school district to notify and identify students who are eligible for services through Title X, Part C of the Federal McKinney-Vento Act. By answering the following questions, it will be determined if your family qualifies for supports and services provided by the school district in accordance to the law.

Name/DOB/Grade of Student: ____

Name of Legal Guardian: ____

Household Address: ______________________________

City/State/Zip Code: ______________________________

Is this the same address your child resided last year? Please circle one: yes / no

Section A

Do you rent or own your home/apartment? Please circle one:

Yes / No

*If you answered **YES**, go to Section C. If you answered **NO**, complete Section B and C.*

Section B (Only complete this section if you answered *NO* in Section A.)

Please put a checkmark beside the best option to describe the student's living situation.

____ House/apartment belonging to or rented by a friend or family member (accompanied by a legal guardian)

____ Living with friends or relatives without a legal guardian present

____ Living with a legal guardian in a camper/hotel/motel/tent/vehicle

____ Living in a temporary shelter/Living without electric or running water

____ Other (Please specify) ____

Section C

Housing and Educational Rights

Students without fixed, regular, and adequate nighttime residences have the following rights:

1. Immediate enrollment in the school they last attended or the local school where they are currently staying even if they do not have all of the documents normally required at the time of enrollment without fear of being separated or treated different due to their housing situations;
2. Transportation to the school of origin for the regular school day;
3. Access to free meals, Title 1 and other educational programs, and transportation to extra-curricular activities to the same extent that is offered to other students.

By signing below, I acknowledge that I have received and understand the above rights.

____

Signature of Guardian *Date*

____

Signature of McKinney-Vento Liaison *Date*