

Dear Parent/Guardian,

Thank you for registering your child with Gaylord Community Schools.

Please provide the following documents to complete the enrollment:

- **ORIGINAL BIRTH CERTIFICATE**
- **PROOF OF RESIDENCY** - must have parent/guardian name and address indicating residency (Ex. driver's license, utility bill, rent/lease agreement, property tax statement, voter's registration, mortgage document, certification from work, etc.)
- **POWER OF ATTORNEY** or **GUARDIANSHIP PAPERWORK** – if student doesn't live with parent
- Latest **IEP** or **504 PLAN** – if student receives special education services
- Copy of current **IMMUNIZATION RECORD**
- Evidence of **VISION & HEARING SCREENING** (Kindergarten only)
(For more information about immunization clinics and/or hearing & vision screenings, contact the Health Department at 1-800-432-4121 or your child's physician)

Please fill out the following forms:

- **STUDENT INFORMATION RECORD** (Emergency Card)
- **KINDERGARTEN WAIVER** (If applicable)
- **REGISTRATION PROOF OF RESIDENCY**
- **CONSENT FOR DISCLOSURE OF IMMUNIZATION INFORMATION**
- **STUDENT INFORMATION SHEET**
- **AFFIRMATION OF PRIOR STUDENT RECORD** (Grades 1-3 / Kindergarten if previously attended school)
- **AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION** (Records Request)
- **TRANSPORTATION REGISTRATION FORM** (If applicable)
- **CONCUSSION AWARENESS ACKNOWLEDGEMENT FORM**

These forms are to be filled out if the enrollment takes place after the school year has started:

- **STUDENT/PARENT AGREEMENT SIGNATURE PAGE**
- **DIRECTORY INFORMATION OPT-OUT FORM**

Your child's school assignment will be based on the following criteria:

- Same elementary school building as sibling/s
- Residence Zone
- Class enrollment

A Healthy Start to Kindergarten



Entering kindergarten is a major milestone, and it's important for your child to be in good health for school. We can help your child's healthy start with:

IMMUNIZATIONS

Kindergarten students must show proof of having had the required immunizations for Michigan schools by the first day of school. Parents wishing to waive immunizations for religious or philosophical reasons must make an appointment at the local health department for waiver education. Students with true medical contraindications to immunizations must see their doctor to receive a *Medical Contraindication Waiver Form*. The health department provides FREE immunizations to children without health insurance and bills Medicaid, Healthy Kids, MiChild, and several private insurances. 800-432-4121

HEARING & VISION SCREENINGS

Your child's ability to see and hear is important to the learning process. **A vision test is required prior to school entry.** Appointments are available in each county for free vision and hearing screenings. In cooperation with your school district, hearing and vision testing is offered through your child's school years according to the following schedule:

Vision: Preschool, grades K, 1, 3, 5, 7 and 9.

Hearing: Preschool, K, grades 2 and 4.

PHYSICAL EXAM

Your school may require a physical exam for school entry. You are encouraged to make an appointment with your family physician.

DENTAL HEALTH SERVICES

New for this year, Michigan passed a law to give children the opportunity to receive a dental assessment prior to starting school, called the Michigan Kindergarten Oral Health Assessment Program (KOHA) to help ensure each student is healthy and ready for a successful school year. If your child(ren) will not be present the day the school has onsite oral health assessments, you may have the [MDHHS Health Appraisal form](#) completed by your dentist. After you download your form, please visit your dental home for completion. Need help or no insurance? The health department partners with Dental Clinics North to ensure health mouths, regardless of insurance status and income—with dental clinics in Alpena, Cheboygan, East Jordan, Gaylord, Mancelona, Petoskey, Traverse City, and West Branch. 877-321-7070.

MEDICAID HEALTHY KIDS & MiChild

Healthy Kids provides free health insurance coverage for pregnant women and children ages 0 to 19. Coverage can include doctor visits, immunizations, prescriptions, hospital expenses, counseling and any other services normally covered by Medicaid. The income allowance for Healthy Kids is higher for pregnant women and infants up to their first birthday (\$4,509 per month for a family of 4; \$3,700 for a family of 4 with children ages 1 to 19).

MiChild is a health insurance program for uninsured children ages 0-19. A family of 4 with a monthly income less than \$4,903 is eligible. Doctor visits, immunizations, prescriptions, dental, vision, counseling & hospital care are all covered. The cost is \$10 per child with a maximum of \$20 per family. If you have another insurance with high deductibles, you may still qualify for MiChild. 800-432-4121.

WOMEN, INFANTS & CHILDREN (WIC)

WIC is a food and nutrition program for pregnant women, breastfeeding women, women who have had a baby in the last six months, infants, and children up to age five. WIC clients are offered nutrition education, information about how children grow and develop, and how to access community resources. WIC provides free foods such as: milk, yogurt, juice, cheese, eggs, cereal, peanut butter, fruits and vegetables, juice, tuna, infant formula, and infant cereal. A family of 4 with a monthly income less than \$4,278 may be eligible. 800-432-4121.

No health insurance? Assistance in applying for free or low-cost health insurance is available by calling the health department at 800-432-4121. No child is denied immunizations due to an inability to pay. Contact your child's primary care provider or your local health department to schedule an appointment.

2023 Recommended Immunizations for Children from Birth Through 6 Years Old

VACCINE	Birth	1 MONTH	2 MONTHS	4 MONTHS	6 MONTHS	12 MONTHS	15 MONTHS	18 MONTHS	19–23 MONTHS	2–3 YEARS	4–6 YEARS
HepB Hepatitis B	HepB	HepB			HepB						
RV* Rotavirus			RV	RV	RV*						
DTaP Diphtheria, Pertussis, & Tetanus			DTaP	DTaP	DTaP		DTaP				DTaP
Hib* Haemophilus influenzae type b			Hib	Hib	Hib*	Hib					
PCV13, PCV15 Pneumococcal disease			PCV	PCV	PCV	PCV					
IPV Polio			IPV	IPV	IPV	IPV					IPV
COVID-19** Coronavirus disease 2019					COVID-19**	COVID-19**	COVID-19**	COVID-19**	COVID-19**	COVID-19**	COVID-19**
Flu* Influenza					Flu (One or Two Doses Yearly)*	Flu (One or Two Doses Yearly)*	Flu (One or Two Doses Yearly)*	Flu (One or Two Doses Yearly)*	Flu (One or Two Doses Yearly)*	Flu (One or Two Doses Yearly)*	Flu (One or Two Doses Yearly)*
MMR Measles, Mumps, & Rubella					MMR	MMR					MMR
Varicella Chickenpox					Varicella	Varicella					Varicella
HepA* Hepatitis A					HepA*	HepA*		HepA*			



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

FOR MORE INFORMATION
Call toll-free: 1-800-CDC-INFO (1-800-232-4636)
Or visit: cdc.gov/vaccines/parents



American Academy
of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

FOR AN APPOINTMENT AT ANY OF THE FOLLOWING LOCATIONS, PLEASE CALL 1-800-432-4121

BELLAIRE	HEALTH DEPARTMENT – 209 Portage Dr.
BOYNE CITY	BOYNE CITY EDUCATION CENTER – 321 S. Park St.
CHARLEVOIX	HEALTH DEPARTMENT – 220 W. Garfield
GAYLORD	HEALTH DEPARTMENT – 95 Livingston Blvd.
MANCELONA	HEALTH DEPARTMENT – 205 Grove St.
PETOSKEY	HEALTH DEPARTMENT – 3434 M-119, Suite A
PELLSTON	HORNET HEALTH CENTER – 172 Park St.

This institution is an equal opportunity provider.

GAYLORD COMMUNITY SCHOOLS

2023-2024 STUDENT INFORMATION RECORD

Please print clearly in ink and provide all information requested. Sign, date, and return to your student's school.

Student's Legal Last Name:	First Name:	Middle Name:	Preferred First Name:
Home Phone:	Gender: (M/F)	Grade	Date of Birth:
Student's Residence Address:		City:	Zip Code:
Mailing Address for Student Mailings:		City:	Zip Code:
School District of Residence:		County of Residence	Birthplace: (City / State / Country)

Please note that if ethnicity and race information is not provided, the US Department of Education requires the school district to provide an answer on our behalf.

ETHNICITY (check one)	RACE (number all that apply)		
<input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic	<input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian / Pacific Islander	<input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> White	<input type="checkbox"/> Asian <input type="checkbox"/> Hispanic / Latino

LANGUAGE SPOKEN AT HOME:(select all that apply) ☐ English ☐ Spanish ☐ Other: (specify) _____

STUDENT LIVES WITH: (check one):

<input type="checkbox"/> Both Parents	<input type="checkbox"/> Mother Only	<input type="checkbox"/> Father Only	<input type="checkbox"/> Foster Parents	<input type="checkbox"/> Other (specify below)
<input type="checkbox"/> Joint Custody	<input type="checkbox"/> Mother / Step-Father	<input type="checkbox"/> Father / Step-Mother	<input type="checkbox"/> Host Family	_____
<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Mother / Other	<input type="checkbox"/> Father / Other	<input type="checkbox"/> Adult Student	_____

STUDENT'S RESIDENCE IS: (check one)

<input type="checkbox"/> Single Family Dwelling	<input type="checkbox"/> More than 1 family in house	<input type="checkbox"/> Motel / Car / Campsite
<input type="checkbox"/> With Friends / Family (other than parent/guardian)	<input type="checkbox"/> Shelter	<input type="checkbox"/> Other

PARENT INFORMATION

Mother Name:	Father Name:
Cell Phone:	Cell Phone
Home Phone:	Home Phone:
Email:	Email:
Work Place/Phone:	Work Place/Phone:
Lives with Student (select one): <input type="checkbox"/> YES <input type="checkbox"/> NO	Lives with Student (select one): <input type="checkbox"/> YES <input type="checkbox"/> NO

If a parent does not live in the same household as the student, send school mailings to this address (Optional):

Is any parent a member of the **Armed Forces** and on active duty (select one): ☐ YES ☐ NO

If there are adults who are restricted from seeing this student OR if there is any other guardianship information **by order of a court**, please list them here.
WE CAN NOT RESTRICT A PARENT WITHOUT LEGAL DOCUMENTATION ON FILE AT THE SCHOOL

OTHER ADULTS RESIDING IN THE HOME: (not including mother and father listed above)		
Name (Last,First)	Relationship	Phone

OFFICE USE ONLY

STUDENT ID:	STUDENT UIC:	AM BUS ROUTE:
RESIDENT STATUS:	DISTRICT OF RESIDENCE:	PM BUS ROUTE:
K-8 HOMEROOM TEACHER:	DISTRICT ENTRY DATE:	Secondary Route Info - AM: PM:

OTHER CHILDREN RESIDING IN THE HOME:			
Name (Last, First)	Birthdate	Grade	School Attending

MEDICAL INFORMATION	
ALLERGIES: _____ Food (List below) (Contact cafe for special diets) _____ Animals (List below) _____ Medications (List below) _____ Other (List below)	CONDITIONS: _____ Asthma - Parent providing inhaler to office? YES NO _____ Diabetes _____ Convulsions / Seizures (Explain below) _____ Other Medical Information (Explain below)
Parent providing Epipen? YES NO	

Please list any allergies and/or provide specific information on conditions checked above:

Please provide any additional information regarding your child's health or medical issues you would like the school to be aware of:

Medical Authorizations and Authorization to Transport in Case of Emergency
In case of an accident or serious illness, I request the school to contact me. If the school cannot reach me, I hereby authorize the school to call the physician indicated and follow his/her instructions. If the physician cannot be reached, the school may make necessary arrangements for the well-being of my child.
Doctor Name: _____ Doctor Phone: _____

PERSONS AUTHORIZED TO PICK UP CHILD FOR EMERGENCY PURPOSE ONLY		
If your child is injured, ill, etc., and needs to leave school, we will first contact the parents listed on the front of this card. If parents are unavailable, we will contact the following individuals authorized to pick up your child from school for emergency purposes only. Your child should know the person. ID may be requested.		
YOUR CHILD WILL NOT BE RELEASED TO ANY UNAUTHORIZED PERSON		
Name (Last, First)	Relationship	Phone

I affirm that as the parent/legal guardian, all information provided is true and accurate and that my child and I reside at the listed address. I understand that any false information provided by me may subject me to legal penalties for perjury.

Signature of Parent / Guardian

Date



KINDERGARTEN WAIVER REQUEST FOR 2023-2024 SCHOOL YEAR

According to Michigan law, if a child residing in Gaylord Community School District is not five years of age on September 1, 2023, but will be five years of age not later than December 1, 2023, the parent or legal guardian of that child may enroll the child in kindergarten for the 2023-2024 school year if the parent or legal guardian notifies the school district in writing.

A school district that receives this written notification may make a recommendation to the parent or legal guardian as to whether the child is not ready to enroll in kindergarten due to the child's age or other factors. Regardless of the district recommendation, the parent or legal guardian retains the sole discretion to determine whether or not to enroll the child in kindergarten if the student is five years of age not later than December 1, 2023.

Student Name: _____ Date of Birth: _____

Verification of Age (*check one*):

☐ Birth Certificate

☐ Government Record

☐ Hospital Record

☐ Court Record

☐ Citizenship Paper

☐ Other: _____
(*specify*)

Evidence of School Readiness (provided by parent/legal guardian):

1) _____

2) _____

3) _____

4) _____

Parent/Guardian Printed Name

Parent/Guardian Signature

Date



REGISTRATION PROOF OF RESIDENCY

Proof of residency Submitted:

- | | |
|---|---|
| <input type="checkbox"/> Driver's license | <input type="checkbox"/> Proof of residency from the County Registrar of Voters |
| <input type="checkbox"/> Lease / Rental agreement | <input type="checkbox"/> Current vehicle registration showing residency address |
| <input type="checkbox"/> Utility bill for the current month | <input type="checkbox"/> Letter from parent's employer on company letterhead |
| <input type="checkbox"/> Property Tax Bill | <input type="checkbox"/> Copy of money order for rent payment |
| <input type="checkbox"/> Mortgage Statement | <input type="checkbox"/> Other _____ |

I declare that I physically reside at: _____.
(complete address)

I declare under the penalty of perjury that the student listed below resides at the above address. I also agree to notify the school within two (2) weeks when residency has been changed. I understand that a new affidavit and a new proof of residency must be submitted. **If I move outside the district, appropriate forms will also be required.**

Falsification of any information or document required for residency verification or the use of the address of another person without actually residing there may result in; withdrawal of student from Gaylord Community Schools and/or being held liable to reimburse the district for expenses incurred to educate this student.

Student Name	Grade

Sibling Names	Grade	School

Parent / Guardian Name

Parent / Guardian Signature

Relationship to Student

Date

Gaylord Community Schools

Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the students name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

I authorize Gaylord Community Schools to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.

Student's Name: _____ Date of Birth: ____/____/____

Student Building: _____ Grade Level: _____

Signature of Parent/Guardian
or Eligible Student: _____ Date: ____/____/____

Printed Parent/Guardian Name: _____

Gaylord Community Schools
Kindergarten Information Sheet

Today's Date: _____

Child's Name: _____ Birthdate: _____ Gender: _____

Name you wish your child to be called in school: _____

Mother's First Name: _____ Last Name: _____

Father's First Name: _____ Last Name: _____

Home Address: _____ City, State, Zip: _____

Mailing Address (if different): _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

With whom does your child reside? _____

Is your child right or left handed? _____ Does your child wear glasses? ___ Yes ___ No

Any known allergies? ___ Yes ___ No

If yes, please explain:

Any known health concerns? _____

___ Heart Trouble ___ Diabetes ___ Seizures ___ Asthma ___ Frequent Colds

___ Eczema ___ Earaches ___ Sore Throats ___ Fears ___ Hemophiliac

___ Bee Stings ___ Epilepsy ___ Nose Bleed ___ Hearing Problems

___ Trouble passing urine or bowel movement ___ Shortness of Breath

___ Other: _____

1. Are there any special things about your child that we should know, such as, illness, divorce, recent move, special fears, etc. that could affect learning?

2. Please list any group experiences your child has participated in (STARS, Head Start, Nursery School, Daycare, Story Hour, etc). Give names and dates.

3. Has your child been identified for any special services such as health, speech/language, IEP or 504? ___ Yes ___ No

If yes, please explain.

4. Does your child take medication on a regular basis? ____ Yes ____ No

If yes, what medication? _____

Reason: _____

5. Does your child's preschool teacher feel he/she is ready to start Kindergarten? ____ Yes ____ No

Please explain:

6. Explain any responsibilities your child has at home.

7. What are some favorite things your child likes to do?

8. Do you celebrate holidays and birthdays in your home? ____ Yes ____ No

If no, please explain:

9. Is your child able to sit in a group setting and listen to a story for ten minutes? ____ Yes ____ No

10. Does your child listen without interrupting while someone else talks? ____ Yes ____ No

11. Does your child know his/her: Phone number? ____ Yes ____ No

Address? ____ Yes ____ No

12. Do you have books/magazines/newspapers at home that your child reads? ____ Yes ____ No

13. What do you expect your child to acquire through the Kindergarten experience?

14. What else would you like your child's teacher to know about your child?

15. Would you be interested in occasionally sending snack items or a food ingredient for an occasional cooking project? ____ Yes ____ No

16. Would you be willing to volunteer in your child's classroom? ____ Yes ____ No

17. Is your child independent in the restroom? ____ Yes ____ No

If no, what is your plan for independence before starting Kindergarten?

Gaylord Community Schools Transportation Registration Form

Transportation questions please call: (989) 705-3022



**Return registration forms to your students' school building during school days.
During the summer months, please return to the Board of Education Office- 615 S. Elm Avenue.**

Date: _____ ☐ New ☐ Change ☐ Moved

* New enrollment registration forms must be completed and returned to the Registrars' Office.

* Families with multiple students need to submit only one form.

* It may take Transportation Dept. up to 5 school days to arrange for busing upon receiving this form.

* More processing time may be necessary during the new school year registration period.

Student Name	School	Grade	Gender

Bus Stop will be at or closest to the students address. We can accommodate ONLY one Pick Up and ONLY one Drop Off location

AM Pick Up (check one) ☐ Home ☐ Day Care ☐ Other Contact Name _____

Address _____ Phone# _____

PM Drop Off (check one) ☐ Home ☐ Day Care ☐ Other Contact Name _____

Address _____ Phone# _____

***Signature of Parent/Guardian*Print _____ Sign _____**

Email: _____ Phone: _____



Please Fill Out Top Half



Joint Custody/Shared Parenting Only If student will be transported to/from a destination other than listed above, please indicate below. **A copy of court papers must be provided with registration form.**

Parent Name _____ Relationship to Student _____

AM Pick Up (check one) ☐ Home ☐ Day Care ☐ Other Contact Name _____

Address _____ Phone# _____

PM Drop Off (check one) ☐ Home ☐ Day Care ☐ Other Contact Name _____

Address _____ Phone# _____

Email: _____ Phone: _____

.....It is the responsibility of the shared custody parents to inform students school of bus schedule weekly.....

Route # _____ Stop _____ BUS START _____

Route # _____ Stop _____ _____

Route ☐ PS ☐ Parent Noti. ☐ Attached ☐ Driver ☐ Notes: _____

UNDERSTANDING CONCUSSIONS

Educational Material for Parents and Students

(Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE), National Athletic Trainers Association

Some Common Symptoms				
Headache	Balance Problems	Sensitivity to Noise	Poor Concentration	Not "Feeling Right"
Pressure in the Head	Double Vision	Sluggishness	Memory Problems	Feeling Irritable
Nausea/Vomiting	Blurry Vision	Haziness	Confusion	Slow Reaction Time
Dizziness	Sensitivity to Light	Fogginess	"Feeling Down"	Sleep Problems
		Grogginess		

WHAT IS A CONCUSSION?

A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning for a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to activity on the day of the injury and not until a health care professional says they are okay to return to activity.

IF YOU SUSPECT A CONCUSSION:

- SEEK MEDICAL ATTENTION RIGHT AWAY**-A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.
- KEEP YOUR STUDENT OUT OF ACTIVITY**-Concussions take time to heal. Don't let the student return to activity the day of the injury and not until a health professional says it is okay. A student who returns to activity too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal.
- TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION(S)**-Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused or has trouble with homework or school assignments
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Appears fatigued
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior or personality changes

CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. If a student sustains a bump, blow or jolt to the head or body and the following danger signs are present, **immediate medical attention** should be sought at the closest emergency department.

• One pupil larger than the other	• Repeated vomiting or nausea	• Becomes increasingly confused or agitated	• Is drowsy and cannot be awakened
• Slurred speech	• Has unusual behavior	• A headache that gets worse	• Convulsions or seizures
• Weakness, numbness or decreased coordination	• Cannot recognize people or places	• Loses consciousness (even briefly)	

WHAT SHOULD YOU DO?

If a student reports one or more symptoms of a concussion after receiving a bump, blow or jolt to the head or body, h/she should be immediately removed from activity (this includes but is not limited to, athletics, PE classes, band, dance, aerobics, theatre and choir.) The student should only return to activity with the permission of a health care professional experienced in evaluating concussions. Rest is key during recovery. Exercising or activities that require a lot of concentration (such as studying, working on the computer or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rest breaks, be given extra help and time, and spend less time reading, writing or on a computer or iPad. After a concussion, returning to sports and school is a gradual process and should be monitored by a health care professional. Concussions affect each individual differently. Some may recover quickly and fully while others may have symptoms that last for days, weeks or even months.

To learn more, go to www.cdc.gov/concussion

PARENTS AND STUDENTS MUST SIGN AND RETURN THE EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the "Understanding Concussions: Education for Parents and Athletes" provided by Gaylord Community Schools.

Student Name Printed

Parent or Guardian Name Printed

Student Name Signature

Parent or Guardian Name Signature

Date

Date

Return this signed form to your school's athletic office or to your coach. The school must keep this on file until the student is age 18. We realize this may not be the first nor the last time you sign and submit this form, as each organization needs to have a copy. Thank you for your cooperation and understanding.

Students and parents please review and keep the educational materials available for future reference.