

CONSENT FOR RELEASE OF EDUCATIONAL RECORDS

Student's Name: _____ Grade: _____

Date of Birth: _____ Age: _____ Sex: _____

This Student will enter Jackson-Milton through one of the following:

- _____ Moved into J-M District as resident
- _____ Attending J-M District under Open Enrollment
- _____ Court/Foster Placement to J-M School District

Former School: _____

Address: _____

Fax: _____ Phone: _____

Release records to: Jackson-Milton Elementary School IRN# 048322
14110 Mahoning Avenue
North Jackson, Ohio 44451

Or fax records to: 330-538-2259 Phone: 330-538-2257

Or email to: Cyndi.smith@jmlocal.com

Please send the following information:

- _____ CUMULATIVE RECORDS, including grades, test scores and the last date of attendance in your school.
- _____ HEALTH DATA, especially immunization records
- _____ PSYCHOLOGICAL REPORTS, including latest I.E.P./M.F.E.
- _____ ANY INFORMATION ON SPECIAL NEEDS
- _____ PROFICIENCY TEST RESULTS
- _____ SSID #

SIGNATURE OF PARENT/GUARDIAN

DATE

Date received: _____



JACKSON-MILTON LOCAL SCHOOLS REGISTRATION FORM

ADMISSION DATE: _____ GRADE: _____ TEACHER: _____ BUS: _____

First Name: _____ Middle Name: _____ Last Name: _____ Male Female

Address of Residence: _____ City: _____ Zip: _____

Mailing Address: _____ Home Phone Number: _____

Parent Broadcast Phone Number (only 1 number will be used): _____

Birth Date: _____ Birth City: _____

Ethnicity: White Black Asian Hispanic/Latino Am. Indian Multiracial

Military Student: ___ Not Applicable ___ A-Active Duty - Student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard) ___ B - National Guard - Student is a dependent of a member of the National Guard (Army National Guard or Air National Guard) ___ C - Reserves - Reserve Duty

Mother's Name: _____ Maiden Name: _____

Mother's Email Address: _____

Father's Name: _____

Father's Email Address: _____

If another adult is living in the home, please fill in name and relationship: _____

Number of brothers: No. of older _____ No. of younger _____ Number of sisters: No. of older _____ No. of younger _____

Other children living in the household (step children etc.) _____

Has the student ever attended the JM school district before? Yes No If yes, last grade attended: _____

School district last attended: _____

Does student receive IEP services or have a 504 Plan? Yes No Special Education 504

Does the student receive Title One Services? Yes No Math Reading

Has the student been identified as Gifted? Yes No

Are there any other special needs which the school should be aware of concerning your child? (i.e., guidance counselor, OT, PT, behavior plan, etc.) _____

Emergency Phone Number and Name of a Relative or Neighbor (Do **NOT** leave this blank..the school **MUST** have this information).

1. _____
2. _____
3. _____

* Over *
Side 2 **MUST** be completed and signed

Information regarding student parents: (Please check all that apply)

	Living at	Legally	Legally	Never	Legal			
	Married	Home	Separated	Divorced	Married	Guardian	Deceased	
Mother:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Child lives with:

- both natural parents
- natural mother, step/adoptive father
- natural father, step/adoptive mother
- only mother
- only father
- grandparents (legal custody)
- other (explain) _____

Part I.

Has the custody of this child ever been altered since the child's birth? (Divorce, foster, etc.)

- No ** If No, please sign this form*. Do NOT complete Part II.
- Yes * If Yes, please complete Part II and sign this form*.

Part II. Enrollment Information is to be completed by Parent/Guardian, or Representative from Agency of Custody if there has ever been a change of custody.

I hereby certify that the information contained on this form is complete and accurate. I understand that incorrect information regarding custody and residence will result in a violation of Section 3313.64 of the Ohio Revised Code.

Does the non-residential parent have visitation rights? _____ Explain: _____

Is there a court decision that states that the non-residential parent should **NOT** receive school information or attend school activities?

Yes No

Please attach a certified copy of the page of the court decision bearing the case numbers and those sections referring to visitation rights and contacts with the school. Also include the page bearing the judge's signature and court seal. This copy should include any and all modifications made as of the date for registration of the child in this school. It is also the responsibility of the parents to inform the school office/principal of any subsequent modifications during the child's tenure at the school.

Parent/Guardian signature

Date

Please describe medical conditions your child has including instructions for school or hospital staff to follow in the event of an emergency: (please note that every effort possible will be made to contact individuals listed on this form first; however realize that it may not always be possible to reach those listed! Give information accordingly. Please list such things as allergies and medical conditions, etc.) This information will be provided to hospital staff (if necessary) or school staff unless instructed otherwise.

Dentist: _____ Phone: _____

Doctor: _____ Phone: _____

Specialist: _____ Phone: _____

Permission to contact child's doctor if necessary: Yes _____ No _____

Health Insurance: _____ Policy # _____ Group # _____

Insured Name: _____

Preferred Hospital: _____

Medications: _____

PLEASE SIGN ONLY ONE LINE BELOW INDICATING YOUR WISHES:

Part I – To Grant Consent:

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by above named doctor, or, in the event the designated preferred practitioner is not available, by another licensed 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 dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's history including allergies, medications being taken, and any physical impairments to which a physician should be alerted are listed above.

Signature of Parent/Guardian

Date

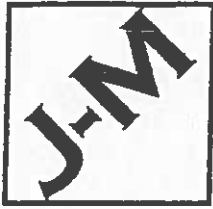
Part II – Refusal to Consent:

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:

Signature of Parent/Guardian

Date

PROOF OF RESIDENCY



Student's Name _____ Birth Date _____ Grade _____ Sex _____

LEGAL ADDRESS

Number Street _____ Telephone/Home _____

City _____ State _____ Zip _____ Telephone/Work _____

I certify that I, the parent/guardian of the above student are residents of the Jackson-Milton Local School District or for open enrollment in an adjacent school district, and we reside at the address indicated. Residency is defined as the location at which you and the child sleep and eat most meals. IT IS A CRIMINAL OFFENSE SUBJECT TO FRAUD CHARGES TO FALSIFY RESIDENCY.

Signature of Parent/Guardian _____ Date _____

ADDITIONAL INFORMATIONAL/MATERIALS REQUIRED BY STATE LAW

1. Birth certificate of child being enrolled
2. Proof of grade placement – current report card or school records
3. Proof of Child Custody or guardianship (if applicable)
4. Proof of Immunization
5. Proof of Social Security Number

Please circle and attach photocopies of appropriate documentation – one from each column.

Column 1

Column 2

- | | |
|---|--|
| <ol style="list-style-type: none"> 1. House Closing Papers 2. Deed 3. Mortgage Documents 4. Building Permit 5. Rental Agreement/Lease 6. Notarized Parent Residency Affidavit (on back) | <ol style="list-style-type: none"> 1. Two current utility bills 2. Two current charge statements 3. Drivers License 4. Tax statement |
|---|--|

FOR OFFICIAL USE – TO BE COMPLETED BY SCHOOL ADMINISTRATOR

APPROVED FOR ENROLLMENT _____ TEMPORARY APPROVAL _____

School _____ Signature of Administrator _____ Date _____

State of Ohio)
County of Mahoning) ss

I, _____, having been duly sworn and
deposed, hereby state and affirm the following:

- 1. I am the parent of _____
- 2. I have legal custody of my above-named child, and s/he presently resides with me.
- 3. My "legal residence" (address) is

(Street Number and Street) (City) (State) (Zip Code)

- 4. For purpose of Affidavit, I intend the term "legal residence" to refer to the location where I eat my meals, sleep on a regular basis, receive my mail, and, if applicable, where I am registered to vote.
- 5. I am the owner/lessee of the address specified above.
- 6. The address specified above is within the Jackson-Milton Local School District

FURTHER AFFIANT SAYETH NAUGHT.

_____, Affiant

Sworn to before me and subscribed in my presence this _____ day of _____
20_____

Notary Public

NOTICE: READ CAREFULLY - Knowingly falsifying this document is a violation of Ohio Revised Code Section 2921.13(A) which is a **FIRST DEGREE MISDEMEANOR** punishable by a prison term of six (6) months and/or a fine of up to \$1000.00. Further the Affiant will be charged (and prosecuted in court, if necessary) to collect all back tuition to the Jackson-Milton Local Schools for all days my child(ren) illegally attended school.

HOME LANGUAGE SURVEY

DATE: _____

SCHOOL DISTRICT: _____

NAME OF STUDENT _____
Family Name First Name Middle I.

DATE OF BIRTH / / PLACE OF BIRTH: _____
Month Day Year City State Country

NAME OF PARENT/GUARDIAN _____
Family Name First Name

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____

For Parents/Guardians:

Please answer the following questions:

1. -- What language did your son/daughter speak when he/she first learned to talk? _____
2. What language does your son/daughter use most frequently at home? _____
3. What language do you use most frequently to your son/daughter? _____
4. What language do the adults at home most often speak? _____
5. How long has your son/daughter attended school in the United States? _____

For School District Personnel:

If the answer to any of the first four questions above is a language other than English, indicate the student's native/home language in EMIS Student Data Element (G-1270), and proceed to assess the student's English language proficiency.

INITIAL ENGLISH LANGUAGE ASSESSMENT

Communication skill

Proficiency Level

Listening	<input type="checkbox"/> Pre-functional	<input type="checkbox"/> Beginning	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Advanced	<input type="checkbox"/> Proficient
Speaking	<input type="checkbox"/> Pre-functional	<input type="checkbox"/> Beginning	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Advanced	<input type="checkbox"/> Proficient
Reading	<input type="checkbox"/> Pre-functional	<input type="checkbox"/> Beginning	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Advanced	<input type="checkbox"/> Proficient
Writing	<input type="checkbox"/> Pre-functional	<input type="checkbox"/> Beginning	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Advanced	<input type="checkbox"/> Proficient
Comprehension*	<input type="checkbox"/> Pre-functional	<input type="checkbox"/> Beginning	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Advanced	<input type="checkbox"/> Proficient
Composite**	<input type="checkbox"/> Pre-functional	<input type="checkbox"/> Beginning	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Advanced	<input type="checkbox"/> Proficient

*The Comprehension level is derived from Listening and Reading

**The Composite level is derived from Listening, Speaking, Reading, Writing and Comprehension

Assessment instrument(s) used: _____

Student is LEP? Yes No

Indicate the student's status as LEP or not LEP in EMIS Student Data Element (GI230)

If student has been in U.S. schools for less than three years, is the student eligible for extended accommodations for statewide academic assessments? Yes No

English Proficiency Levels—Descriptions

Language Proficiency Levels	Listening	Speaking	Reading	Writing
<p>0 Level Minimal/Functional</p>	<ul style="list-style-type: none"> Has zero to very limited ability in understanding spoken English Relies on non-verbal cues such as gestures and facial expressions, and requires frequent repetition/rephrasing to understand spoken language May understand some isolated words, some social conventions, and simple directions, commands and questions 	<ul style="list-style-type: none"> Has zero to very limited ability in speaking English May say or repeat common phrases, words and formulaic language May be able to provide some basic information in response to requests and questions Can ask one or two-word questions without regard to structure and intonation 	<ul style="list-style-type: none"> Has zero to very limited ability in reading English May demonstrate some basic concepts of print (front-to-back, top to-bottom, left-to-right) May distinguish letters from other symbolic representations May follow one-step directions depicted graphically 	<ul style="list-style-type: none"> Has zero to very limited ability in writing English Can participate in writing activities by drawing pictures May be able to copy letters or form them from memory May be able to copy some words May attempt to apply some writing conventions, but often does so inappropriately
<p>1 Level Beginning</p>	<ul style="list-style-type: none"> Understands simple, short statements and questions on a well-known topic within a familiar context Can follow simple multi-step directions Can identify the main idea and some details of short conversations or simple orally-delivered text on a familiar topic May still need repetition and rephrasing 	<ul style="list-style-type: none"> Predominantly uses formulaic patterns and memorized phrases Uses language that is often marked by the lack of tense, number, and agreement Uses school-social vocabulary that is limited to key words and has little or no academic vocabulary Responds to questions usually with one or two-word answers 	<ul style="list-style-type: none"> Begins to identify the names of both upper and lower case letters of the alphabet Can identify where words begin and end Can follow multi-step directions depicted graphically During read aloud, gets meaning primarily from pictures and the teacher's tone of voice and gestures 	<ul style="list-style-type: none"> Produces writing that is marked by the lack of tense, number, and agreement Makes frequent errors in mechanics such as punctuation and capitalization Writes most effectively when supported by a visual, a shared experience, or scaffolding Can begin to revise or edit own writing with teacher support
<p>2 Level Intermediate</p>	<ul style="list-style-type: none"> Shows understanding simple questions and statements on familiar topics Often requires restatements in graphic terms or at a lower rate Can follow many simple directions Shows appropriate responses when read or told a story (example – laughs at humor) Has difficulty comprehending academic-related 	<ul style="list-style-type: none"> Can communicate ideas and feelings in English, but with some difficulty Speaks coherently, but with hesitations and with grammatical and syntactic errors Can retell a simple story, but detail may be lacking Can respond appropriately to many questions, but with errors in grammar and vocabulary 	<ul style="list-style-type: none"> Reads simple printed material within a familiar context Understands short discourse on familiar topics. Has a small repertoire of high frequency words Partially uses details to extract meaning Partially perceives the feeling and tone in a poem or story Has some weaknesses in predicting from details 	<ul style="list-style-type: none"> Composes short paragraphs that are mostly intelligible Begins to edit for sentence-level structure, spelling and mechanics and revises for content, organization and vocabulary, usually with the support of the teacher Writes with less dependency on visual supports, shared experiences, and scaffolding
<p>3 Level Advanced</p>	<ul style="list-style-type: none"> Understands conversations in most school/social settings Understands main ideas and significant relevant details of extended discussions or presentations on familiar and relevant academic topics May ask for clarification on oral information related to academic content Understands multiple meanings of words and can use context clues to understand messages 	<ul style="list-style-type: none"> Speaks in coherent, fluent sentences, but with occasional errors in vocabulary and syntax Has little difficulty communicating personal ideas and feeling in English Can respond appropriately to many questions in classroom settings, but makes some errors in more complex grammatical structures Can often use language to connect, tell and expand on a topic; and can begin to use it to reason 	<ul style="list-style-type: none"> Can read familiar text with little teacher or visual support; still needs those supports when reading to comprehend unfamiliar text Has oral fluency and uses self-monitoring and self-correction strategies when necessary Can identify main idea of many reading passages Able to identify most specific facts within a text May have some difficulty using details to make predictions 	<ul style="list-style-type: none"> Writes simple social correspondence with some errors in spelling and punctuation May have some difficulty in producing complex sentences Produces writing that generally addresses given topic Produces writing that is generally intelligible but lacking grade-level quality Produces writing that generally expresses complete thoughts
<p>4 Level Proficient</p>	<ul style="list-style-type: none"> Shows understanding of academic topical conversations without difficulty Can follow complex and multi-level directions without difficulty Shows understanding of oral information provided via electronic media 	<ul style="list-style-type: none"> Speaks English fluently in social and grade-level academic settings Produces speech that include a variety of adverbs and transitional signals Participates in classroom discussions without difficulty Demonstrates control of age-appropriate syntax and vocabulary when speaking Can use language effectively to connect, tell, expand, and reason 	<ul style="list-style-type: none"> Reads and understands factual information in non-technical prose as well as discussion on concrete topics related to special events Comprehends standard newspaper items addressed to the general reader, correspondence reports and technical materials Shows understanding of the main idea Understands figurative language in a poem 	<ul style="list-style-type: none"> Writes short papers and clearly expresses statements of position, points of view and arguments Shows good control of sentence structure, spelling, and vocabulary Produces writing with wide range of vocabulary Edits for sentence-level structure, spelling, and mechanics and revise for content, organization and vocabulary

Sources: North Carolina Department of Education, 1999; Iowa Department of Education, 2000; IDEA Reading and Writing Proficiency Tests, Examiner's Manual, 1993, Ballard and Tighe; The State Collaborative on Assessment and Student Standards (SCASS) for Assessing Limited English Proficient Students and American Institutes for Research (AIR), English Language Development Assessment K-2 Test Administration Manual, 2006.

Student Name _____ Birth Date ____/____/____

Per United States Department of Education requirements, when collecting race/ethnicity information districts must collect this information by using a two part question found below.

Part 1: ETHNICITY

Is the student Hispanic/Latino (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race) _____ Yes _____ No

Regardless of whether your answer is Yes or No to Part 1, you must also select 1 or more racial groups in Part 2.

Part 2: RACIAL GROUP

Is the student from one or more of the following racial groups (check all that apply):

- (W) White
People who have origins in any of the original peoples of Europe, North Africa, or the Middle East.
- (B) Black or African American
Persons having origins in any of the black racial groups in Africa.
- (A) Asian
Persons having origins in any of the original peoples of the Far East, Southeast Asia, or The Indian subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- (I) American Indian or Alaskan Native
Persons having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.
- (P) Native Hawaiian or Other Pacific Islander
Persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

PARENT OR GUARDIAN REFUSES TO LIST CHILD'S ETHNICITY AND RACIAL GROUP

(parent or guardian) refuse to designate the ethnicity of my child and understand that the school district is required by the United States Department of Education to determine the ethnicity of my child based on their observation of the student.

Parent or Guardian Signature _____ Date ____/____/____

FOR SCHOOL USE ONLY WHEN PARENT REFUSES TO LIST CHILD'S ETHNICITY AND RACIAL GROUP ABOVE

School District's determination of child's ethnicity based on observation:

- Hispanic/Latino White Black or African American
- Asian American Indian or Alaskan Native
- Native Hawaiian or Other Pacific Islander

Name of School District employee determining child's ethnicity (please print) _____

Employee Signature: _____ Date: ____/____/____

EMERGENCY CARE INFORMATION FOR THE SCHOOL CLINIC

STUDENT NAME _____ Today's Date _____

Address _____ City _____ Zip _____

Phone _____ Teacher _____ Grade _____ Date of Birth _____

Residential Parent/Guardian

Name/Relationship _____ Daytime Phone _____ Alt Phone _____

Name/Relationship _____ Daytime Phone _____ Alt Phone _____

Other Emergency Contacts	{	1. _____ Daytime Phone _____ Alt Phone _____
		2. _____ Daytime Phone _____ Alt Phone _____
		3. _____ Daytime Phone _____ Alt Phone _____

Please identify any health concerns that school personnel should be aware of:

Will student take medication at school? No ___ Yes ___ *If Yes, Permission to Dispense Form must be completed*

Will student need medication available while on bus? No ___ Yes ___ Medication Name _____

Allergies No ___ Yes ___ Specify _____

Epi-Pen No ___ Yes ___ *If yes, Epi-Pen Authorization Form must be completed.*

Asthma No ___ Yes ___ *If yes, explain severity* _____

Inhaler No ___ Yes ___ *If yes, Inhaler Authorization Form must be completed.*

Seizures No ___ Yes ___ Emergency seizure medications? _____

Name of medications

Diabetes No ___ Yes ___ Emergency diabetic medications? _____

Name of medications

Does student take any medication regularly? No ___ Yes ___ Specify _____

Name of medications, amt taken, how often

Previous Surgeries (be specific) _____

Previous concussion/head injury & year _____

Hearing or Vision problems (be specific) _____

Behavior/emotional problems _____

Are there any other medical conditions that school personnel should be aware of? _____



A NOTE FROM THE SCHOOL NURSE

SHOULD I KEEP MY CHILD HOME FROM SCHOOL BECAUSE OF ILLNESS?

In order for your child to be available for learning and to control communicable disease in school, it is very important for you to keep your child at home when he or she:

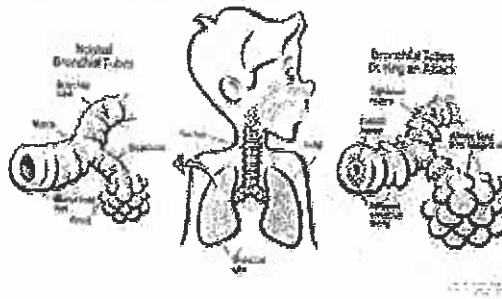
- Has a temperature of 100 degrees or more. Your child should remain at home in bed for the day and should be fever-free for 24 hours (without the aid of Tylenol or Motrin) before returning to school, as many children rebound with a temperature. This has been very frustrating lately as many children are returning to school after being sent home the day before with a fever, only to be sent home with fever again. Please consider that we need to attempt to control the spread of illness.
- Has been diagnosed with a strep infection. Your child should be on antibiotics for 24 hours before returning to school.
- Has vomited during the night or in the morning.
- Has persistent diarrhea during the night and into the morning.
- Has a moist productive cough, chest congestion, or discolored nasal discharge.
- Has red swollen eyes that itch and are draining pus (woke up with eyes glued shut).

If your child has been diagnosed with a communicable illness, contact your doctor or the school nurse to discuss when your child should return to school. Examples include, but are not limited to chicken pox, impetigo, scabies, lice and ringworm. Please inform the nurse or secretary when your child has a communicable illness so that a health alert may be distributed to classmates. Please send your child back to school with the necessary physician's release form indicating your child has been cleared for school.

WHAT HAPPENS IF MY CHILD SHOULD GET SICK AT SCHOOL?

When it is determined that a student should be sent home as a result of illness or injury, a parent/guardian who has legal custody will be notified and asked to come pick up the child from school. The student can be released to someone other than the parent if that person has been designated on the emergency medical form by the parent. Please inform the office of any change in phone numbers for work or home or an added cell phone or pager to assist us in being able to reach you in a timely manner. If your child is ill at school, he/she needs to be picked up from school in a timely manner, as the health office is very small and other children coming in will be at risk of exposure to the illness.

Does your child have a health condition such as
Asthma, Allergies, Diabetes, Seizure Disorders, etc???



Please notify the School Nurse, Mrs. Baker, in the event your child has an illness or medical condition. Preparations need to be started before the first day of the school year. Mrs. Baker can be reached at 330-538-2257 X 1405.

Students who will need medication during school hours must have written permission from the physician. A form has been attached for your convenience. (Please note, a different form is needed for asthma inhalers and epi-pens—call Mrs. Baker to request those forms.) Medication must be brought to the school by the parent. The medication must be in the original container. Please contact the School Nurse, Mrs. Baker, with any questions or concerns (330-538-2257 X1405).

Ohio School Health History

To be used for Pre-and Elementary School

School _____
 Enrolled _____

Child's name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Birthdate
Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian American <input type="checkbox"/> Other			
Who is the child's legal guardian?	Who does the child live with?	Child's address	
Parent/Guardian	Parent/Guardian Address	Home phone number	

Social Service History

Mark the box if you have contact with any of the following agencies:

- Child Protective Services if yes, Case worker's name: _____
- Legal/Court System
- Family Counseling Services
- Mental Health Provider
- Other: _____

Mark the box if you or your child receive any of the following medical assistance:

- SSI, Disability Healthy Start Insurance (Blue Cross/Blue Shield, HMO)
- LEAP Medicaid/CHIP Other: _____

Family History

Please list first and last name of all the child's family members including parents and siblings.

Name	Birthdate	Gender	Health Concerns	Is the child in school?	If so, where?
1.					
2.					
3.					
4.					
5.					

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain briefly.
How old was the mother when the child was born? Was the infant born: What was the infants birth weight? <input type="checkbox"/> Full term <input type="checkbox"/> Early <input type="checkbox"/> Late _____ Lbs. _____ Oz.
Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No

Developmental History

Please give the approximate age at which this child:

Walked alone _____ Spoke in sentences _____

Toilet trained _____ Dressed Self _____

How does this child's development compare to other children, such as his or her brothers/sisters or playmates?

About the same Delayed Advanced

Allergies

Please list and describe allergies or reactions.

Medications/drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

Injuries, Illnesses & Hospitalizations

Please list any severe injuries, illnesses and hospitalizations including inpatient and outpatient surgical procedures.

Injuries/Illness/Hospitalizations	Age	If hospitalized, please explain.

Does your child always wear a seatbelt while riding in automobiles

Yes No

Does the student wear a helmet when bicycling, skating/rollerblading or riding a motorcycle?

Yes No

Medication Information

Please describe any medications that your child takes daily and frequently.

Name of Medication	What is the medication taken for?	How often is the medication taken? What time is the medication administered?

Health Conditions

Please check any medical conditions that the child currently has or has had in the past.

- | | |
|---|--|
| <input checked="" type="checkbox"/> Abnormal spinal curvature (Scoliosis) | <input type="checkbox"/> Hemophilia |
| <input checked="" type="checkbox"/> Allergies/hayfever | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Anaphylactic reaction | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Juvenile Arthritis |
| <input type="checkbox"/> Attention deficit disorder (ADD) | <input type="checkbox"/> Kidney disease type _____ |
| <input type="checkbox"/> Behavior problem | <input type="checkbox"/> Measles (10 day) |
| <input type="checkbox"/> Birth or congenital malformation | <input type="checkbox"/> Meningitis or Encephalitis |
| <input type="checkbox"/> Cancer type _____ | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Chickenpox when _____ | <input type="checkbox"/> Mutism |
| <input type="checkbox"/> Chronic diarrhea or constipation | <input type="checkbox"/> Near-drowning/Near-suffocation |
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Nervous twitches or tics |
| <input type="checkbox"/> Concern about relation with siblings or friends | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure disorder/Epilepsy |
| <input type="checkbox"/> Eczema/Chronic skin conditions | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Eye problems, poor vision | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Toothaches or dental problems |
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Tourette's Syndrome |
| <input type="checkbox"/> Heart disease type _____ | <input type="checkbox"/> Urinary tract infections |
| | <input type="checkbox"/> Wetting during the day or night |

Behavioral History

The child is usually: Very active Normally active Rather inactive

Has your child every been violent or acted out in the following manner towards adults or children:

- Hitting Kicking Biting Fighting Scratching

Do you have any concern about how your child gets along with other children?

- Yes No If yes, explain _____

Please add any comments or concerns you have about your child's health, development, behavior, family, or home life that you would like the school to be aware of. _____

Is this student enrolled in special education course? Yes No



Ohio Immunization Summary for School Attendance

VACCINES	FALL 2022 Immunizations for School Attendance
DTaP/DT Tdap/Td Diphtheria, Tetanus, Pertussis	<p>K-12 Four or more doses of DTaP or DT, or any combination. If all four doses were given <i>before the fourth birthday</i>, a fifth dose is <i>required</i>. If the fourth dose was administered at least six months after the third dose, and on or after the fourth birthday, a fifth dose is not required.*</p> <p>Grades 1-12 Three doses of Td or a combination of Td and Tdap is the minimum acceptable for children ages 7 years and older with the first dose being Tdap. Minimum spacing of four weeks between doses 1 and 2, and six months between doses 2 and 3.</p> <p>Grade 7 One dose of Tdap vaccine must be administered on or after the 10th birthday. ** <i>All students in grades 8-12 must have one documented Tdap dose.</i></p>
POLIO	<p>K-12 Three or more doses of IPV. <i>The FINAL dose must be administered on or after the fourth birthday</i>, regardless of the number of previous doses <i>and there must be six months spacing between doses 2 and 3</i>. If a combination of OPV and IPV was received, four doses of either vaccine are required.</p>
MMR Measles, Mumps, Rubella	<p>K-12 Two doses of MMR. The first dose must be administered on or after the first birthday. The second dose must be administered at least 28 days after the first dose.</p>
HEP B Hepatitis B	<p>K-12 Three doses of hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least eight weeks after the second dose. The last dose in the series (third or fourth dose) must not be administered before age 24 weeks.</p>
VARICELLA (Chickenpox)	<p>K-12 Two doses of varicella vaccine must be administered prior to entry. The first dose must be administered on or after the first birthday. The second dose should be administered at least three months after the first dose; however, if the second dose is administered at least 28 days after the first dose, it is considered valid.</p>
MCV4 Meningococcal	<p>Grade 7 One dose of meningococcal (serogroup A, C, W, and Y) vaccine <u>must be administered prior to seventh grade entry</u>. All students grades 8-11 must have one documented dose of MCV4.</p> <p>Grade 12 Two doses of MCV4 by age 16 years, with a minimum interval of eight weeks between doses. If the first dose was given on or after the 16th birthday, only one dose is required. ****</p>

NOTES:

- Vaccine should be administered according to the most recent version of the *Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger* or the *Catch-up immunization schedule for persons aged 4 months-18 years who start late or who are more than 1 month behind*, as published by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. Schedules are available for print or download through www.cdc.gov/vaccines/schedules/index.html.
- Vaccine doses administered less than or equal to four days before the minimum interval or age are valid (grace period). Doses administered greater than or equal to five days earlier than the minimum interval or age are not valid doses and should be repeated when age appropriate. If MMR and varicella are not given on the same day, the doses must be separated by at least 28 days with no grace period.
- For additional information, please refer to the [Ohio Revised Code 3313.67](#) and [3313.671](#) for school attendance and the [QDH Director's Journal Entry](#) on required vaccines for child care and school. These documents list required and recommended immunizations and indicate exemptions to immunizations.
- Please contact the Ohio Department of Health Immunization Program at 800-282-0546 or 614-466-4643 with questions or concerns.

* Recommended DTaP or DT minimum intervals for kindergarten students are four weeks between the first and second doses, and the second and third doses; and six months between the third and fourth doses and the fourth and fifth doses. If a fifth dose is administered prior to the fourth birthday, a sixth dose is recommended but not required.

** Tdap can be given regardless of the interval since the last tetanus or diphtheria-toxoid containing vaccine. Children age 7 years or older with an incomplete history of DTaP should be given Tdap as the first dose in the catch-up series. If the series began at age 7-9 years, the fourth dose must be a Tdap given at age 11-12 years. If the third dose of Tdap is given at age 10 years, no additional dose is needed at age 11-12 years.

*** The final polio dose in the IPV series must be administered at age 4 years or older with at least six months between the final and previous dose.

**** Recommended MCV4 minimum interval of at least eight weeks between the first and second doses. If the first dose of MCV4 was administered on or after the 16th birthday, a second dose is not required. If a pupil is in 12th grade and is 15 years old or younger, only one dose is required. Currently, there are no school entry requirements for meningococcal B vaccine.



Jackson-Milton Local Schools

RETURN THIS FORM IMMEDIATELY
Students risk exclusion for failure to return this form

Date: _____ Grade: _____
Teacher: _____

Student Name: _____ Male ____ Female ____
Address: _____ City _____ Zip: _____
Home Phone: _____ Date of Birth: _____ Age: _____

Military Student: ____ Not Applicable ____ A – Active Duty – Student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard) ____ B – National Guard – Student is a dependent of a member of the National Guard (Army National Guard or Air National Guard) ____ C – Reserves – Reserve Duty

Primary Contact & Relationship

*Please notify office of any change in address and/or custody

Name: _____ Name: _____
Address: _____ Address: _____
City, Zip _____ City, Zip: _____
Phone Number: _____ Phone Number: _____
Email Address: _____ Email Address: _____
Relationship to Student: _____ Relationship to Student: _____
Daycare/Other: _____ Phone: _____
Siblings' Name & Date of Birth: 1. _____ 3. _____
2. _____ 4. _____

If Parents Are Separated Or Divorced Who Has Custody?

Custodial Parent/Guardian: _____
Address: _____ Phone: _____

If Parents Are Not Available, In Case Of Emergency Call:

(The individual listed will be permitted to sign this student out of school when parent can't be contacted)

1. Name: _____ 3. Name: _____
Phone: _____ Phone: _____
Relationship to Student: _____ Relationship to Student: _____
2. Name: _____ 4. Name: _____
Phone: _____ Phone: _____
Relationship to Student: _____ Relationship to Student: _____

In Case Of Emergency Dismissal, My Child Should Go To This Local Address:

OVER
SIDE 2 MUST BE COMPLETED

Please describe medical conditions your child has including instructions for school or hospital staff to follow in the event of an emergency: (please note that every effort possible will be made to contact individuals listed on this form first; however realize that it may not always be possible to reach those listed! Give information accordingly. Please list such things as allergies and medical conditions, etc.) This information will be provided to hospital staff (if necessary) or school staff unless instructed otherwise.

Dentist: _____ Phone: _____

Doctor: _____ Phone: _____

Specialist: _____ Phone: _____

Permission to contact child's doctor if necessary: Yes _____ No _____

Health Insurance: _____ Policy # _____ Group # _____
Insured Name: _____

Preferred Hospital: _____

Medications: _____

PLEASE SIGN ONLY ONE LINE BELOW INDICATING YOUR WISHES:

Part I – To Grant Consent:

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by above named doctor, or, in the event the designated preferred practitioner is not available, by another licensed 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 dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's history including allergies, medications being taken, and any physical impairments to which a physician should be alerted are listed above.

Signature of Parent/Guardian Date

Part II – Refusal to 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:

Signature of Parent/Guardian Date