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)

	Married	Living at Home	Legally Separated	Legally Divorced	Never Married	Legal Guardian	Deceased
Mother:	☐	☐	☐	☐	☐	☐	☐
Father:	☐	☐	☐	☐	☐	☐	☐

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

Jackson-Milton Local Schools

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

Date: ____________ Grade: ________
Teacher: ______________________

Name

Student Name: ______________________ Male ____ Female ____
Address: ______________________ City ______________ Zip: ________
Home Phone: ______________ Date of Birth: ________ Age: ____ SS# ____________

Primary Contact & Relationship

☐ **Please check** if any change in address and/or custody

Name: ______________	Name: ______________
Address: ______________	Address: ______________
City, Zip ______________	City, Zip: ______________
Work Phone #'s: ______________	Work Phone #'s: ______________
Other Phone #'s ______________	Other Phone #'s ______________
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: ______________
   Phone: ______________
   Relationship to Student: ______________
2. Name: ______________
   Phone: ______________
   Relationship to Student: ______________
3. Name: ______________
   Phone: ______________
   Relationship to Student: ______________
4. Name: ______________
   Phone: ______________
   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:

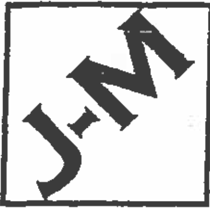
I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

____

____

______________________________ ______________

Signature of Parent/Guardian Date



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

1. House Closing Papers
2. Deed
3. Mortgage Documents
4. Building Permit
5. Rental Agreement/Lease
6. Notarized Parent Residency Affidavit (on back)

Column 2

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)
) :ss
County of Mahoning)

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.

Ohio | Department of Education

Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

Student Name: *(First Name and Last Name)*	**Student Date of Birth:** *(mm/dd/yyyy)*
Communication Preferences Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.	1. In what language(s) would your family prefer to communicate with the school? ______________________________
Language Background Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.	2. What language did your child learn first? ______________________________ 3. What language does your child use the most at home? ______________________________ 4. What languages are used in your home? ______________________________
Prior Education Responses about your child's birth country and previous education give us Information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.	5. In what country was your child born? ________________ 6. Has your child ever received formal education outside of the United States? ⌋ Yes Δ No If yes, how many years/months? ________________ If yes, what was the language of instruction? ________________ 7. Has your child attended school in the United States? Δ Yes Δ No If yes, when did your child first attend a school in the United States? ______ / ______ / ________ Month Day Year
Additional Information Please share additional information to help us understand your child's language experiences and educational background.	

Parent/Guardian First Name:____________________ Parent/Guardian Last Name: ____________________

Parent/Guardian Signature:____________________ Today's Date: *(mm/dd/yyyy)* ____________________

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: https://www2.ed.gov/about/offices/list/ocr/ellresources.html

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Ohio | Department of Education

(Appendix A, continued)

COMPLETED BY SCHOOL EMPLOYEE

1. **Check.** Confirm the following statements related to the administration of Ohio's language usage survey:

   - ☐ The district or school presented the language usage survey, to the extent practicable, in a language and form that the parent or guardian understood.
   - ☐ The district or school informed the parent(s) or guardian(s) of the form's purpose. The language usage survey only is used to understand students' linguistic experiences and educational background.
   - ☐ The district or school reports information from the language usage survey in the appropriate Educational Management Information System (EMIS) records.
   - ☐ For students enrolling from other U.S. schools and districts, school officials request previous language survey data and refer to the information when identifying English learners.
   - ☐ Results of the language usage survey are kept with the student's cumulative records and follow the student if he/she transfers to another district or school.

2. **Note.** Record additional information to assist the review of the language usage survey.

3. **Record.** Indicate responses from the language usage survey in the table below. Refer to the Language Usage Survey Annotations on page 2 for item-specific guidance.

Student's native language See Language Usage Survey Question 2. Report for all students in EMIS.	______________________
Student's home language See Language Usage Survey Question 3. Report only for English learners in EMIS.	______________________
Potential English learner See Language Usage Survey Questions 2-4.	☐ Yes. Assess the student's English proficiency. ☐ No. Do not assess the student's English proficiency.
Immigrant student status See Language Usage Survey Questions 5-7. Report for all students in EMIS.	☐ Yes, the student is an immigrant child. ☐ No, the child is not an immigrant child.

4. **Validate.** Complete the information below.

______________________	______________________
Signature of validating school employee	Date (mm/dd/yyyy)
______________________	______________________
Printed name of validating school employee	Name of school or school district

JM Jackson-Milton

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**
I (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:

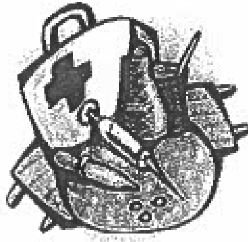
_____ Hispanic/Latino _____ White _____ Black or African American

_____ 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:____/____/____



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).

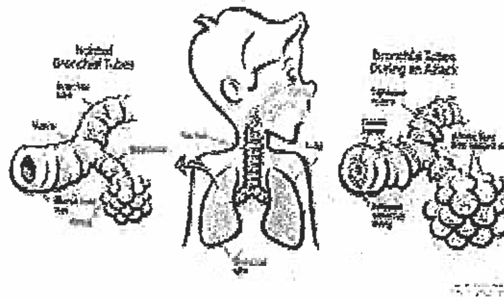
If your child has been diagnosed with a communicable illness, contact your doctor or the school nurse to discuss when your child should return to school. Examples include, but are not limited to chicken pox, impetigo, scabies, lice and ringworm. Please inform the nurse or secretary when your child has 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).

RETURN FORM TO SCHOOL NURSE WITHOUT DELAY

JACKSON-MILTON LOCAL SCHOOLS

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?____________________

____

____

Ohio School Health History

To be used for Pre-and Elementary School

School________________________

Enrolled________________________

Child's name	Gender ☐ Male ☐ Female	Age	Birthdate

Ethnicity
☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ 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
- ☐ LEAP
- ☐ Healthy Start
- ☐ Medicaid/CHIP
- ☐ Insurance (Blue Cross/Blue Shield, HMO)
- ☐ 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?
☐ Yes ☐ No If yes, explain briefly.

How old was the mother when the child was born? Was the infant born: ☐ Full term ☐ Early ☐ Late
What was the infants birth weight? ____Lbs. ____Oz.

Did the infant have any sickness or problems?
☐ Yes ☐ 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.

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

Department of Health

Ohio Immunization Summary for School Attendance

VACCINES	FALL 2022 Immunizations for School Attendance
DTaP/DT Tdap/Td Diphtheria, Tetanus, Pertussis	**K-12** Four or more doses of DTaP or DT, or any combination. If all four doses were given *before the fourth birthday*, a fifth dose is *required*. 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.* **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. **Grade 7** One dose of Tdap vaccine must be administered on or after the 10th birthday. ** ***All students in grades 8-12 must have one documented Tdap dose.***
POLIO	**K-12** Three or more doses of IPV. *The FINAL dose must be administered on or after the fourth birthday,* regardless of the number of previous doses ***and** there must be six months spacing between doses 2 and 3.* If a combination of OPV and IPV was received, four doses of either vaccine are required.
MMR Measles, Mumps, Rubella	**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.
HEP B Hepatitis B	**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.
VARICELLA (Chickenpox)	**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.
MCV4 Meningococcal	**Grade 7** One dose of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to seventh grade entry. **All students grades 8-11 must have one documented dose of MCV4.** **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. ****

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 ODH 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.*

Last updated 12/01/2021.

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