GAYLORD COMMUNITY SCHOOLS

North Ohio Elementary
Ms. Celeste Shiffer, Principal

South Maple Elementary
Ms. Diane Parker, Principal

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.)
- **COMPLETE IMMUNIZATION or Immunization Waiver**
- **POWER OF ATTORNEY** or **GUARDIANSHIP PAPERWORK** – if student doesn't live with parent
- Latest **IEP** or **504 PLAN** – if student receives special education services
- Evidence of **VISION & HEARING SCREENING** (Kindergarten only)
  (For more information about immunization clinics and/or hearing & vision screenings, contact the Health Department at 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**

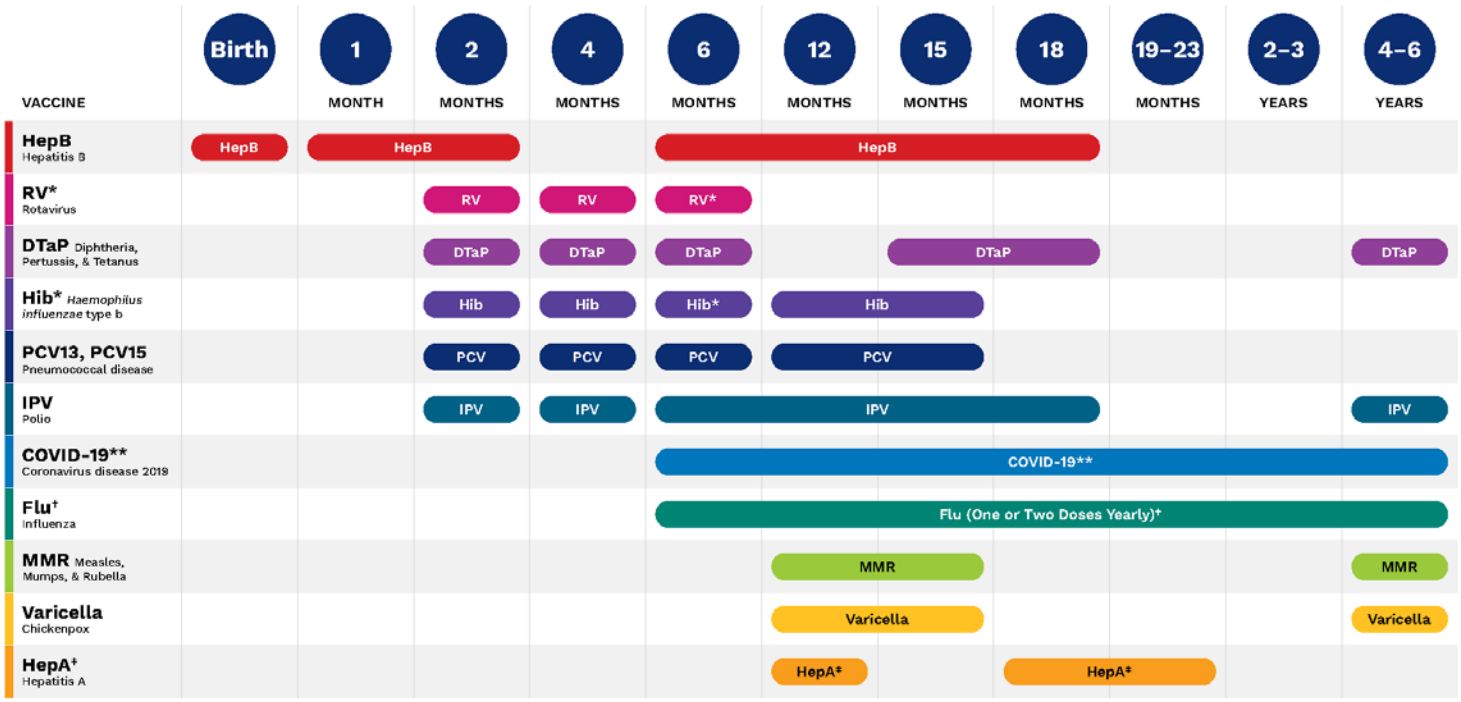
These forms are to be filled out if the enrollment takes place after the school year has started:

- **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

2023 Recommended Immunizations for Children from Birth Through 6 Years Old



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

AAFP American Academy of Family Physicians

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.

HEALTH DEPARTMENT of Northwest Michigan

GAYLORD COMMUNITY SCHOOLS
2024-2025 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)		
__ Non-Hispanic	__ African American	__ American Indian / Alaska Native	__ Asian
__ Hispanic	__ Native Hawaiian / Pacific Islander	__ White	__ Hispanic / Latino

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

STUDENT LIVES WITH: (check one):

__ Both Parents	__ Mother Only	__ Father Only	__ Foster Parents	__ Other (specify below)
__ Joint Custody	__ Mother / Step-Father	__ Father / Step-Mother	__ Host Family	_____
__ Legal Guardian	__ Mother / Other	__ Father / Other	__ Adult Student	_____

STUDENT'S RESIDENCE IS: (check one)

__ Single Family Dwelling	__ More than 1 family in house	__ Motel / Car / Campsite
__ With Friends / Family (other than parent/guardian)	__ Shelter	__ 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): __ YES __ NO	**Lives with Student (select one): __ YES __ 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

GAYLORD COMMUNITY SCHOOLS

REGISTRATION PROOF OF RESIDENCY

Proof of residency Submitted:

O Driver's license
O Lease / Rental agreement
O Utility bill for the current month
O Property Tax Bill
O Mortgage Statement
O Proof of residency from the County Registrar of Voters
O Current vehicle registration showing residency address
O Letter from parent's employer on company letterhead
O Copy of money order for rent payment
O 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

615 South Elm Avenue, Gaylord, Michigan 49735
Phone: (989)705-3080 Fax: (989)732-6029
www.gaylordschools.com

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: _____

Rev.8/2/18

Gaylord Community Schools

First Through Third Grade Information

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, or ECDD? ____ Yes ____ No*
   If yes, please explain.

   _____

4. *Does your child take medication on a regular basis? ____Yes ____No*
   If yes, what medication? _____
   Reason: _____

5. *How does your child spend his/her leisure time?*

   _____

   _____

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 his/her educational 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*

GAYLORD COMMUNITY SCHOOLS

AFFIRMATION OF PRIOR STUDENT RECORD

[NOT a request for records]

Student Name: _____ Grade: _____

Previous School: _____

Previous School District: _____

➢ DISCIPLINE

My child has been suspended or expelled from any public or private school in Michigan or any other state for an offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence against persons and/or property committed on school premises, at any school sponsored activity, or on a public or private conveyance providing transportation to and from a school or school sponsored activity.

☐ NO ☐ YES

➢ SPECIAL EDUCATION SERVICES / Section 504

My child received the following services:

☐ SPECIAL EDUCATION SERVICES ☐ Section 504

The undersigned affirms that the above information is what parent/guardian indicated in above student's registration form.

_____ _____

District Representative Date

========== **BOTTOM PORTION TO BE FILLED OUT BY PREVIOUS SCHOOL** ==========

From: _____

(name of previous school)

Please check one:

☐ According to our records, we verify that the information provided above **IS** correct.

☐ According to our records, the information provided above **IS NOT** correct.

Please email the following student records to GCS.REGISTRAR@GAYLORD.K12.MI.US or fax to 989-732-6029 :

Attachment: ☐ Transcript/Report Card ☐ IEP, MET, 504 Plan, etc. ☐ Discipline Records

_____ _____ _____

Signature of Sending District Administrator or Designee Title Date

615 South Elm Avenue, Gaylord, Michigan 49735
Phone: (989)705-3080 Fax: (989)732-6029
www.gaylordschools.com

Revised 02/01/23

GAYLORD COMMUNITY SCHOOLS

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Student Name: _____ DOB: _____ Grade: _____

Has your child ever attended Gaylord Community Schools? ◯ NO ◯ YES School Bldg: SME NOE GMS GIS GHS
Year/s attended: _____

School Transferring From: _____ School District: _____

Previous School Address: _____

Phone No.: _____ Fax No.: _____

I authorize release of the following records for the child listed above:

	COMPLETE CUMULATIVE		TRANSCRIPT		CURRENT MET, IEP, 504 Plan		Confidential Files (IEPC)
	BIRTH CERTIFICATE		WITHDRAWAL GRADES		MEDICAL FILE		Psychological & Diagnostic Reports
	IMMUNIZATION RECORD		CURRENT SCHEDULE		SOCIAL WORKER REPORTS		DISCIPLINE RECORD

Has the above child received special education services? ◯ NO ◯ YES

Has/have the above child received section 504 services? ◯ NO ◯ YES

If marked yes, area(s) services provided: _____

* Parental permission is no longer required when records are requested by authorized school personnel in compliance with "Federal Education Rights and Privacy Act, Final Rule on Educational Records, Federal Register, June 17, 1976, Vol41, No. II, Page 2465."

* The Michigan Attorney General ruled on April 23, 1982 that a school district may not withhold records of a student who transfer to another district if the student has an outstanding obligation to the school district.

Please accept this as a notification that Gaylord Community Schools will be requesting an FTE adjustment per Section 25 for the above student.

UIC No. _____ First Date of Attendance: _____

_____
Signature of GCS Administrator

PLEASE FOWARD STUDENT RECORDS TO SCHOOL INDICATED BELOW:

Date Request Sent: _____

☐ GCS District Registrar 615 S. Elm Ave. Gaylord, MI 49735 Phone: 989-705-3027 Fax: 989-732-6029	☐ North Ohio Elem. 912 North Ohio Ave. Gaylord, MI 49735 Phone: 989-731-2648 Fax: 989-731-3387	☐ South Maple Elem. 650 East Fifth Ave. Gaylord, MI 49735 Phone: 989-731-0648 Fax: 989-731-0095	☐ Gaylord Intermediate School 240 East Fourth Avenue Gaylord, MI 49735 Phone: 989-731-0856 Fax: 989-732-6475	☐ Gaylord Middle School 600 East Fifth Avenue Gaylord, MI 49735 Phone: 989-731-0848 Fax: 989-732-2632	☐ Gaylord High School 90 Livingston Blvd. Gaylord, MI 49735 Phone: 989-731-0969 Fax: 989-731-2585

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:

1. **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.
2. **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.
3. **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**
- **Slurred speech**
- **Weakness, numbness or decreased coordination**
- **Repeated vomiting or nausea**
- **Has unusual behavior**
- **Cannot recognize people or places**
- **Becomes increasingly confused or agitated**
- **A headache that gets worse**
- **Loses consciousness (even briefly)**
- **Is drowsy and cannot be awakened**
- **Convulsions or seizures**

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.