

# BACK-TO-SCHOOL PACKET

2024-2025  
School Year





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Dear CPS Families,

Welcome back!

We're excited to kick-off the school year with you! Please find the 2024-2025 Back-to-School packet enclosed. **All back-to-school forms are available digitally on FOCUS.**

Collecting back-to-school information online is preferred to ensure fewer errors. Online forms are available in Spanish, French, and Arabic. Benefits to filling out the forms online include:

- You only need to check and update existing information
- Ensures student information is not duplicated

To access online documents, create an account on FOCUS and search for your child with their FOCUS ID number, first and last name, and date of birth.

If you need help, your child's school has staff that are trained to use the Online Registration System.

If you fill out forms digitally, you do not need to fill out paper forms. However, since many families prefer paper forms, inside this document, you will find all paper forms families are required to fill out, including:

- Health history and consent forms
- CPS' Mobile Device Agreement and Acceptable Use Policy
- Parent Involvement Survey
- Positive Behavior Intervention Supports
- CPS District Calendar

Families are also responsible for understanding Emergency Weather Procedures, which can be found on our website at <https://www.cps-k12.org/our-students/severe-weather-procedures>.

To get a copy of the forms in Spanish, French or Arabic, please contact your school.

If you would like to register a student for preschool, please contact early childhood education at (513) 363-0240 or visit <https://www.cps-k12.org/our-district/preschool>.

Thank you, and we look forward to a great school year!



## Students with Disabilities

Cincinnati Public Schools is conducting an Intensive Awareness Campaign in accordance with the requirements of the Individuals with Disabilities Education Improvement Act (IDEIA 2004), the Ohio Administrative Code, the Ohio Revised Code, and the Operating Standards for Ohio Educational Agencies Serving Children with Disabilities.

Public school districts and the Ohio Department of Education are trying to **identify children with disabilities, from birth through age 21**, who may need special education and related services.

**For children birth to age 3, a disability means an established condition known to result in either a developmental delay or a documented developmental delay.**

**For children ages 3 through 5, a disability means a child has a documented deficit in one or more of the following developmental areas:**

- Communication
- Vision
- Hearing
- Motor skills
- Social emotional/behavioral functioning
- Self-help skills
- Cognitive development

**For school-age children, a disability means a child has been identified as having one or more of the following conditions:**

- Autism
- Deaf-blindness
- Hearing impairment (including deafness)
- Multiple disabilities
- Orthopedic impairment
- Other health impairment
- Specific learning disability
- Speech or language impairment
- Traumatic brain injury
- Visual impairment (including blindness)
- Intellectual disabilities
- Emotional disturbance

### **Your public school offers:**

- Evaluation for all children with suspected disabilities, birth through age 21
- Education for all children with disabilities ages 3 through 21 years

### **When school staff is notified about a child who is suspected of having a disability:**

- The child's parents are contacted and informed of their rights, as required by the Individuals with Disabilities Education Improvement Act (IDEIA 2004), the Ohio Revised Code, and the State Board of Education's Operating Standards for Ohio's Schools Serving Children with Disabilities.
- Arrangements are made to review all information and documentation pertaining to the suspected disability.

**If you know a child who is suspected of having a disability and is not being served, tell staff at the child's school or contact CPS' Student Services Department, (513) 363-0280.**





## Districtwide Discipline Policy

### Positive Behavior Intervention Supports

- There is a district-wide Code of Conduct for students.
- The Code of Conduct is updated annually and available for review on CPS' website: [www.cps-k12.org/codeofconduct](http://www.cps-k12.org/codeofconduct)

Cincinnati Public Schools strives to create a Positive School Culture in all our schools, aimed at creating a safe and orderly environment that keeps students in school and engaged in learning.

Part of this Positive School Culture is a district-wide **Code of Conduct** that provides clear and explicit expectations for student behavior, specifies guidelines for teaching social skills to students, describes methods to help correct behavior and outlines the consequences for misbehavior.

In addition to the Code of Conduct, each school is required to develop its own Positive Behavior Intervention Supports Plan through its Positive Behavior Intervention Supports Committee. This plan must include a range of options that teach behavior expectations to students. Schools must communicate this plan to parents and students. Parents should know and understand the Positive Behavior Intervention Supports Plan at their children's schools.

### Searches of Student and Property

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Students will be subject to searches by metal detectors and/or by hand on a random basis, or with reasonable suspicion, by district administrators or security personnel.

The district may search: A student's outer clothing, pockets, book bags or other property; a student's locker; a vehicle driven to school by a student and parked on school property.

Students have no expectation of privacy in cell phones or other electronic devices brought to school. If there is reasonable suspicion that a search will reveal a violation of school rules, cell phones and other electronic devices may be confiscated and searched, including searching calls, e-mails, contacts, texts, and other communications or Internet access.

Students will be treated with respect during a search. Any student failing to cooperate during a search will be subject to discipline under the CPS Code of Conduct.

**The Cincinnati Public School District is not responsible for damaged, lost or stolen personal items.**

*The Cincinnati Public School District provides equal educational, vocational, and employment opportunities for all people without regard to race, gender, ethnicity, color, age, disability, religion, national origin, creed, sexual orientation, or affiliation with a union or professional organization, and provides equal access to the Boy Scouts and other designated groups. The district is in compliance with Title VI, Title IX and Section 504 of the Vocational Rehabilitation Act. For additional information, contact the Title IX Coordinator or Section 504 Student Coordinator: (513) 363-0000 TDD: (513) 363-0124*



Dear CPS Families, Parents & Guardians,

Providing our CPS students and staff with a safe educational environment remains one of our top priorities. As a part of an April 2022 School Board resolution, we are encouraging our families to implement secure firearm storage at home to ensure children don't have access and/or bring a gun to school. A firearm stored safely at home is the first step. We have partnered with the "Be Smart For Kids" program to provide you with key information, statistics, and the ability to get a gun lock.



**Secure** all guns in your homes and vehicles;  
**Model** responsible behavior around guns;  
**Ask** about unsecured guns in other homes;  
**Recognize** the role of guns in suicide;  
**Tell** your peers to Be SMART

Studies of school-based gun violence point to the same significant point for intervention: addressing students' unauthorized access to guns in the home. One recent study of targeted school violence incidents from 2008 to 2017 found that 76% of the firearms were obtained from the home of a parent or close relative.

What's more, unsecured guns in the home pose a risk to students *outside* school. Firearms are now the leading cause of death among children in the U.S. Every year, nearly 350 children under the age of 18 unintentionally shoot themselves or someone else. Distressingly, almost 40% of child gun deaths are suicides—nearly 700 child gun suicides annually (pre-pandemic). In most incidents, the gun used was one that belonged to someone in the student's home.

**4.6 million  
American children  
live in homes with  
guns that are both  
loaded and  
unlocked.**

One study found that 87% of kids know where their parents' guns are kept, and 60% have handled them. Research shows that secure firearm storage practices are associated with up to an 85% reduction in the risk of self-inflicted and unintentional firearm injuries among children and teens. Storing firearms securely protects any child in your home as well as students throughout the school district and community.

As an additional measure to ensure our parents are informed and aware about secure firearm storage, our school staff will share this information while registering their children for the 2024-2025 school year and confirm this within our student information system.

You can also learn more about secure firearm storage, talking to your children about guns, and facts and resources on child firearm suicide at **BeSMARTforKids.org**. Please take the necessary steps in protecting your family, community, and schools – 'Be Smart' and secure your firearms.

Yours in Service,

Shauna Murphy  
Interim Superintendent



## **Update to the Meal and Educational Benefits Application**

Dear CPS Families,

During the pandemic, free breakfast and lunch meals were provided to all students regardless of income verification.

For Fall 2024, breakfast will continue to be provided at no cost to all students, but expired federal waivers as of July 1, 2022 will require parents/guardians with children attending the below three CPS schools to complete a Meal & Educational Benefits Application to qualify for free lunch:

- Hyde Park School
- Kilgour School
- Walnut Hills High School

Paid meals will be \$1.75 at elementary schools and \$2.00 at secondary schools.

Parents/guardians at these three schools may access and fill out the online application available on the CPS webpage or complete a paper application at your child's school.

For more information about our Student Dining Services and Free and Reduced Meal programs, please visit: [www.cps-k12.org/studentdining](http://www.cps-k12.org/studentdining).



## Request to Restrict Privacy Information and Photos/Video

Federal and Ohio laws prohibit Cincinnati Public Schools (CPS) from publicly releasing student information, photos and video/audio without authorization, except for designated "Directory Information." Under Ohio public records law, CPS is required upon request to provide the Directory Information to any member of the public who requests it. Per **Board Policy No. 8330**, CPS defines Directory Information as the following:

A student's name, school, grade level, parent-guardian's name, home address, telephone number, email address, participation in officially recognized activities and sports, and awards received.

CPS' primary purpose for releasing Directory Information is to highlight student accomplishments. Sometimes, the district and/or school takes photos and captures video/audio that may be placed on the district's websites, social media channels, approved publications and/or may appear within a broadcast media news story.

**If you agree** that CPS may release your child's Directory Information, photos, video/audio, **you do not need to return this form** and no further action is needed. If you do not want CPS to release directory information, photos, video/audio or to military recruiters, please check the applicable boxes below.

### Directory and General Public Release

Parents, legal guardians, or students aged 18 and older may refuse to allow CPS to release Directory Information by checking the box returning this form to the school by the end of September.

CPS **may not** release Directory Information about my child.

### Media Release

Parents, legal guardians, or students aged 18 and older may refuse to allow CPS to release photos and video/audio that features students on the district's websites, social media channels, and publications or may appear on broadcast news. Opting-out does not cover events or performances that are open to the public.

CPS **may not** release photos and/or video/audio of my child.

### Military Recruiters:

Per federal law, CPS must release the names, addresses and telephone numbers of high school students to military recruiters, unless the parent, legal guardian, or student aged 18 and over specifically objects.

CPS **may not** release my child's name, address and phone number to military recruiters.

### Student Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_ Home Room: \_\_\_\_\_

Please  I am the student, and I am 18 years of age or older.

check one:  I am the parent or legal guardian of the student and the student is under 18 years of age.

Parent/Guardian Name (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parents/guardians and/or eligible students who believe their rights under the Federal Education Rights and Privacy Act (FERPA) have been violated may file a complaint with: Family Policy Compliance Office, U.S. Department of Education, 400 Maryland Avenue, SW, Washington, D.C., 20202-4605.

[www.ed.gov/offices/OM/fpco](http://www.ed.gov/offices/OM/fpco). Informal inquiries may be sent to the Family Policy Compliance Office via email: [FERPA@ed.gov](mailto:FERPA@ed.gov).





**Community Learning Center**  
Cincinnati Public Schools  
2651 Burnet Avenue  
Cincinnati, Ohio 45219  
Phone: (513) 363-0154

## 2024-25 Parent / Guardian Consent Form Student Computerized Records

The Cincinnati Public Schools partners with a number of organizations to assist with addressing student needs.

The partners offer an array of services related to the following areas: tutoring, mentoring, health, and after school services. Services may be organized through Resource Coordinators who are assigned to individual schools.

The Resource Coordinators or partner organizations may request access to the student computerized records system, including IEP data, to view personally identifiable student data. This data may also be shared with staff and volunteers working with the partner organization. This would enable the Resource Coordinators and partner organizations to identify and assign appropriate services to students. If granted access, the Resource Coordinator or partner organizations must maintain the confidentiality of student information, and not re-disclose the information to persons not identified in this consent. The Resource Coordinator and partner organizations are only permitted to access student records in their own program and to the extent necessary to perform his/her duties. In addition, the Resource Coordinator or partner organizations may share information about his/her program with school district staff and other partners listed below, in order to better serve students.

Confidential information may only be shared to the extent that the information is relevant to the student's educational progress, safety, or well-being. Student information may be disclosed in a grave medical emergency which necessitates facilitation of medical care.

A parent/guardian authorization is required to allow the coordinator and partner organizations access to your child's data. Please select the partners below that you give consent to.

Resource Coordinator and/or school will enter partner options below

<ul style="list-style-type: none"> <li>● _____</li> <li>● _____</li> <li>● _____</li> </ul>	<ul style="list-style-type: none"> <li>● _____</li> <li>● _____</li> <li>● _____</li> </ul>
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**I have read the above and consent to all partners listed above serving Cincinnati Public Schools to release, obtain, and exchange my child's information from school district staff and partners listed above.**

\_\_\_\_\_  
**Print Parent/Guardian Name**

\_\_\_\_\_  
**Print Student Name (one student per form)**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**School Name**

\_\_\_\_\_  
**Grade**

\_\_\_\_\_  
**Phone Number**

<p><b>For Office Use Only</b> Student ID #: _____</p>
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# Student Acceptable Use Policy and Internet/Network Safety Agreement

Cincinnati Public Schools 2024-2025 School Year

*Grades PreK - 3*

## Student Agreement

I WILL...	
	Always handle my iPad or computer properly.
	Only use the websites my teachers approve of.
	Always keep my username and password private.
	Always keep food and drinks away from my iPad or computer, because another student may use the device.
	Always be respectful and kind with using the internet.
	Always report anything on the internet that makes me sad, scared, uncomfortable or unsafe.
	Always take responsibility if I damage my iPad or computer.



# Student Acceptable Use Policy and Internet/Network Safety Agreement

Cincinnati Public Schools 2024-2025 School Year

*Grades PreK - 3*

## 1. **What is an AUP?**

*Acceptable Usage Policy.* An agreement or promise that you will follow the rules when using school computers, iPads, and other devices.

## 2. **Why is the AUP important?**

Our school wants to keep you and the equipment you use safe. The AUP tells you the rules and your job when using computers, iPads, and devices.

The AUP reminds us that when you are using computers, iPads, and other devices it is not private. Your teacher is watching and so are others on the internet. You must remember to be respectful, responsible, and safe.

## 3. **What is the MDA?**

*The Mobile Device Agreement.* An agreement or promise that you will take care of the school computers, iPads, and other devices.

## 4. **Why is the MDA important?**

*The Mobile Device Agreement* helps remind you to keep the computers, iPads, and devices in good working condition. It also tells you there are consequences if you destroy or damage the computer, iPad, or device.



# **Student Acceptable Use Policy and Internet/Network Safety Agreement**

Cincinnati Public Schools 2024-2025 School Year

*Grades PreK - 3*







For all questions, please call the Family Technology  
Support Center: 513-363-0688





**Student Acceptable Use Policy and Internet/Network Safety Agreement**  
Cincinnati Public Schools 2024-2025 School Year  
*Grades 4-12*

**Student Agreement**

I WILL...	
	I understand that I am expected to use my assigned device safely, responsibly, and for educational purposes only
	I will treat my equipment with care and respect. I understand that I am responsible for the proper use of technology that is issued to me in my name.
	I will be a respectful digital citizen. I will not cyberbully, send inappropriate messages or use inappropriate language.
	I will notify an adult if an internet/security issue is suspected or identified.
	I will return the device in the condition in which I received it (keyboard/screen cleaned off; no food particles), because I understand another student may be assigned this device.
	I will follow the student responsibilities listed below and the Cincinnati Public Schools (CPS) <a href="#">Code of Conduct</a> while using technology.

CPS "Code of Conduct" can be found at: <https://www.cps-k12.org/our-students/policies-and-guidelines/code-of-conduct>

**Student Responsibilities**

1. **I will be responsible for my assigned device and accounts.** I will not share my account information, passwords, or other information used to access programs to anyone. I also know that I should not access accounts under someone else's name. If I see someone else's information, when using a shared device, I

will tell an adult and wait to use the device until an adult has removed the material.

2. **I will be kind and respectful in my language and how I treat others while online.** I will not intentionally be hurtful, bully, harass, intimidate, stalk, or threaten other students and staff ("cyberbullying"). I will only use language on the internet and in my school email that I would use in the classroom with my teacher. I will tell a teacher if I see anything hurtful to another student online.
3. **I will use the CPS Network responsibly.** I will not access, post, display, or otherwise use material that is not school appropriate. I will not look up web pages, apps, or documents that have content that is inappropriate. I will not create or share photos, videos, or texts/chats that are inappropriate. Inappropriate content can include things that are discriminatory, mean-spirited, improper, sexually explicit, violent, or disruptive language. I will not download any files, including music and video files, unless a teacher gives me permission.
4. **I will be honest about who I am online.** I will not pretend to be anyone else online. I will not send email, create an account, or post any words, pictures, or sounds using someone else's name. I will not use another person's login name or password. I will not "plagiarize." When I use information from a website, I need to let people know where I got the information and cite my sources. I will obey copyright laws and will not download words, pictures, video, or music that belongs to someone else.
5. **I will protect the security of the CPS Network.** I will not try to change security settings or install any software on school devices without permission. I will not use a phone, personal laptop, or any electronic device in school without a teacher's permission. I will not "hack" into any systems to manipulate data of the district of other users.
6. **I will protect all CPS property that is assigned to me.** I will not break or destroy any equipment on purpose. I will not move any equipment, including keyboards and mice, without permission. I will not disrupt or harm district technology (such as destroying district equipment, placing a virus on district computers, adding or removing a computer program without permission, changing settings on shared computers, etc).
7. **I will protect myself and others while online.** I will not publish any material on a school website, wiki, blog, podcast, or discussion group without permission. I will not publish a picture, including my picture, with the person's first or last name attached. I will not give personal information (such as name, address, telephone number, Social Security number, or other personal information) of mine, another student, staff member, or anyone else without permission or with the intent to threaten, intimidate, harass, or ridicule that person.

## Frequently Asked Questions

### What is an AUP?

AUP stands for "Acceptable Use Policy." It means that you agree to only do "acceptable" things when you are using Cincinnati Public Schools (CPS) internet and technology. For details on what is "acceptable" see the above agreements and responsibilities as well as your building and/or classroom rules. The AUP is an agreement that you must digitally sign for you to be allowed to use CPS network and equipment.

## **What is an MDA?**

MDA stands for “Mobile Device Agreement.” It means that you agree to handle devices and equipment in a safe and secure manner. Please note that within this agreement it states you may be charged for repair or replacement costs to your device if there is damage caused by:

- A. horseplay in the vicinity of the device.
- B. spilling liquid or food on the device.
- C. closing the monitor on an object (e.g. pen, pencil, calculator, paper clip, etc.).
- D. the device not being cleaned off when turned in.
- E. theft of the device resulting from not securing the device properly.
- F. loss of missing devices.

## **Why does CPS have an AUP/MDA?**

A lot of people use the Cincinnati Public Schools' network and school devices. We need to make sure that our devices and printers are in working order and that everyone is safe and comfortable when using the network.

## **Why do I have to be responsible for what I do on the CPS District Network?**

It is important that we are all responsible digital citizens in order for all staff and students to have safe spaces to learn and grow. Using the internet and district technology is a privilege given to help in achieving that goal. Please understand that the CPS network, web pages, and email accounts are NOT private. CPS staff, as well as the Cincinnati Police, are able to “monitor” all activity on school devices. (Including everything you read, what you write, and the web pages that you visit on school devices). This is done to ensure that district technology is being used for safe and appropriate activities. Pause and think before you use your device to ensure you don't do anything online that you would not want your teachers or parents to see.

## **What happens if a student does not follow the rules in the AUP/MDA?**

The CPS AUP/MDA are in place to ensure we all have safe spaces to learn and grow while using technology. If you see anything online that does not follow the agreements and responsibilities, report it to a teacher or adult IMMEDIATELY! Students who do not follow the CPS AUP/MDA will receive consequences up to the loss of device privileges. Consequences will be determined by your building principal according to your school's rules and procedures. Please note the Cincinnati Police Department will be contacted if your actions have broken a law. Lastly, you could be responsible for fees associated with your device(s).



## **Education Center - Office of Environmental Health and Safety**

2651 Burnet Avenue Cincinnati OH 45219-5381 Phone: 513-363-0107 Fax 513-363-0373

DATE: 6/20/2024

TO: Parents, Staff, School Organizations and Employee Representative Groups

RE: AHERA Annual Notification

This memo is to notify all parents, staff, school organizations and employee representative groups that the Cincinnati Public School District complies with the United States Environmental Protection Agency's (U.S. EPA) Asbestos Hazard Emergency Response Act (AHERA) regulations.

These regulations require every private, parochial and public school district to inspect all school buildings for asbestos containing material, assess the condition of the asbestos material and draw up a plan on how the district is to manage the asbestos containing material.

The Cincinnati Public School District has had all buildings inspected for asbestos and has compiled the results in the Asbestos Hazard Emergency Response Act (AHERA) – *Asbestos Management Plan*. The plan for each school is located in the main school office and is available for review.

The Asbestos Management Plan should be checked when planning all building renovations so as to prevent the disturbance of asbestos. All planned repairs and renovations of school district buildings, which involve the disturbance of known asbestos containing material, are completed by certified persons who are trained to work with asbestos material. These projects are completed in a safe manner by following procedures detailed in the Asbestos Management Plan.

The school district continues to monitor the condition of all asbestos containing building material by having district employees check the condition every six months. In addition, the district has trained inspectors from outside the district conduct a major re-inspection of all buildings every three years. The results of these required inspections are available in the Asbestos Management Plan.

If your school has had asbestos abatement projects, you will find a brief description of the projects in the Asbestos Management Plan.

Any questions or concerns about the implementation of the AHERA regulations should be given to the building administrator who will contact the Environmental Health and Safety Manager, if necessary, to obtain clarification.

Sincerely,

Steven Knapik

Environmental Health and Safety Manager



Sign Up Today



- Educate your children **on when and how** to dial 9-1-1 in an emergency, and make sure your children know their home address.
- Create a Smart911 Safety Profile at **www.smart911.com** to provide 9-1-1 staff and First Responders — police officers, firefighters and Emergency Medical Services — with information that can help protect your family in an emergency.

**Signing up for Smart911** gives First Responders important information you have provided that can help **locate you and help you** in an emergency.

**Other safety reminders:**

- To avoid injury, choose your child's backpack carefully, making sure it won't get too heavy. A loaded backpack should weigh no more than 10 percent to 20 percent of your child's body weight.
- Don't put your child's name on a backpack, or on any outer clothing. If your child's name is easily readable, it makes it easier for strangers to approach and begin a conversation.
- Teach your children that **any adult they don't know is a stranger**, even if the person looks nice, and that they should never go anywhere with a stranger.



June 2024

Dear Parent or Guardian,

Please complete the necessary health forms and return to your child's school. These forms may be obtained from your school or online: <https://www.cps-k12.org/our-students/forms>.

The **Emergency Medical Authorization** form is needed in case of an emergency at school. It gives the school permission to get emergency treatment for children who become ill or injured while at school, when parents or guardians cannot be reached.

The **Health History Update** form gives school personnel pertinent health information regarding your child and is **required** by Ohio law. It must be updated every school year. Additional forms may be needed for children with chronic conditions (such as asthma, diabetes seizure disorder, sickle cell disease). These may be obtained through the school health office at your child's school.

Complete the **CPS Administration of Medication** form only if your child needs **prescription medication** during the school day. This must be completed and signed by **both** the licensed medical provider and parent before medication can be given at school.

The **Authorization for Administration of Over-the-Counter Medications at School** form gives the nurse, school health assistant, or principal designee permission to give the medications listed on the Over-the-Counter Medication form to your child for comfort measures. This must be completed and signed by **both** the licensed medical provider and parent before medication can be given at school.

The **School Based Health Center Enrollment Packet** may also be included. If you would like your child to receive the services listed, complete and return the packet to the school health office. If your student is or has already consented to the School Based Health Center, please complete the HIPPA consent attached. This must be completed annually.

Thank you in advance for your attention to these important documents and for partnering with us in guarding your child's wellness!

A handwritten signature in blue ink, appearing to read "Grant Mussman".

Grant Mussman, MD, MHSA  
Interim Health Commissioner  
Cincinnati Health Department

A handwritten signature in blue ink, appearing to read "Denise M. Saker".

Denise M. Saker, MD, MPH, FAAP  
Interim Medical Director  
Cincinnati Health Department



**Tuberculosis (TB) Risk Assessment:**

**Is your child in contact with any of the following people:** Immigrants from another country, someone diagnosed with or treated for TB, incarcerated children or adults, HIV infected, homeless, nursing home residents, institutionalized children or adults, illegal drug users, migrant farm workers?

**For your child, please circle Yes or No below, and explain any Yes answers.**

Diagnosed or treated for TB? \_\_\_ No \_\_\_ Yes \_\_\_\_\_

Immigration from another country? \_\_\_ No \_\_\_ Yes \_\_\_\_\_

Traveled to another country? \_\_\_ No \_\_\_ Yes \_\_\_\_\_

Ever been in jail or in 2020 (Juvenile Detention Center)? \_\_\_ No \_\_\_ Yes \_\_\_\_\_

**Student's Name** \_\_\_\_\_

Has your child received the COVID-19 Vaccine? \_\_\_ No \_\_\_ Yes Dates: \_\_\_\_\_

Please list any **CURRENT** health problems or conditions your child has (may be same as above): \_\_\_\_\_

Please list any allergies (include **food, medications, environmental, seasonal, etc.**):

Please list any dietary restrictions (medical or non-medical) \_\_\_\_\_

Does your child see a specialist? Yes \_\_\_ No \_\_\_ If yes, please list condition, doctor's name, and phone number:

Please list any medications (prescribed or over-the-counter) your child takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches): \_\_\_\_\_

**SPECIAL NOTE:** If your child must take any medications at school, including emergency medications (such as an inhaler or Epi Pen), you **must** fill out a CPS Administration of Medication form (available at the school).

Has your student had any operations, serious injuries or overnight hospital stays? No \_\_\_ Yes \_\_\_; please explain:

Has your child ever been pregnant? No \_\_\_ Yes \_\_\_; please explain:

Has your child ever been a victim of abuse? No \_\_\_ Yes \_\_\_; please explain:

Has anything bad, scary or sad happened to your family? No \_\_\_ Yes \_\_\_; please explain:

**School Concerns**

Is your child in a special education class? No \_\_\_ Yes \_\_\_; please explain: \_\_\_\_\_

Has your child repeated a grade? No \_\_\_ Yes \_\_\_; details: \_\_\_\_\_

Does your child get into trouble at school? No \_\_\_ Yes \_\_\_; details: \_\_\_\_\_

What are your child's grades on the report card? \_\_\_\_\_

Any changes recently in grades? No \_\_\_ Yes \_\_\_

**Name of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**How can we reach you during school hours?** Cell: \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_



# Emergency Medical Authorization Form

Fill out this form and return it to your child's school.

Student's Name: \_\_\_\_\_ ID #: \_\_\_\_\_ Homeroom: \_\_\_\_\_ Birth Date: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Year: \_\_\_\_\_

Student's Address: \_\_\_\_\_ Apt.: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Purpose** — To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

### Residential Parent or Guardian

Parent / Guardian Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Parent / Guardian Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Other's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Name of Relative or Child-care Provider: \_\_\_\_\_

Relationship: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

### PART I or PART II MUST BE COMPLETED

**PART I: TO GRANT CONSENT** I hereby give consent for the following medical-care providers and local hospital to be called:

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Local Hospital: \_\_\_\_\_ Emergency Room Phone: \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

**PART II: REFUSAL TO GRANT 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 to take the following action:

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

## Cincinnati Health Department School-Based Health Center Enrollment Packet

**PLEASE COMPLETE AND SIGN ALL PAGES.**

STUDENT/PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Gender: M/F Trans: MTF/FTM or Non-Binary  
 Child's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Medical Card/Insurance ID: \_\_\_\_\_  
 CareSource  Molina  Buckeye  Paramount  United Health Care  No Insurance  OTHER \_\_\_\_\_

**MEDICAL HEALTH CARE SERVICES:**



**YES**, I consent for my child to receive **MEDICAL CARE** including routine well childcare\* (e.g. work, daycare, and sports physicals) appropriate immunizations, fluoride varnish and treatment for illness or injury including over the counter medications unless emergency services are needed. (\*Note: well child care includes vision/hearing screening, urine and blood tests, immunizations as needed, and an external genital exam when appropriate). My child may be **TRANSPORTED/ACCOMPANIED** to and from medical services by a school designee. I, the parent or guardian of above-named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and the Cincinnati Public School District (CPS), its board personal injury or damage resulting from the transportation of my student to and from health services. **\*Please note: in Ohio, minors may access confidential service for sexually transmitted infections and family planning, including provision of contraception such as condoms or birth control pills without parental consent.**

**NO**, I do not wish for my child to receive **MEDICAL CARE** at the school-based health center (SBHC)

**DENTAL HEALTH CARE SERVICES:**



**YES**, I consent for my child to receive **DENTAL SERVICES** at a Cincinnati Health Department (CHD) Center or school-based/mobile clinic including preventive care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals if necessary. Sealants and other preventive procedures will be provided at school. My child may be **TRANSPORTED/ACCOMPANIED** to and from dental services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

**NO**, I do not wish for my child to receive **DENTAL SERVICES**

**EYE CENTER SERVICES:**



**YES**, I consent for my child to receive **EYE CENTER SERVICES** at the OneSight Vision Center at Oyler School or Academy of World Languages, which may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction. My child may be **TRANSPORTED/ACCOMPANIED** to and from eye center services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

**NO**, I do not wish for my child to receive **VISION SERVICES**

⇒ \_\_\_\_\_  
 Parent / Guardian Signature (or patient if 18 or older)      Parent/Guardian Name (PRINT)      DATE  
 Phone (best) \_\_\_\_\_ Phone #2 \_\_\_\_\_ Phone #3 \_\_\_\_\_  
 ADDRESS      STREET      APT      CITY      STATE      ZIP  
 I give consent for my child to obtain the services that I have marked in the boxes above. I agree to the terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in Program Description form (attached). **Consent in effect until terminated in writing** by Parent/Guardian.



STUDENT/PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

**To provide health services for your child we need the following information:**

Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian's Date of Birth: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Parent/Guardian's Social Security No.: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Your Child's Health History**

❖ Do you have a **Primary Care Doctor**?  YES  NO

Doctor Name/Clinic: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Date of last complete yearly physical examination (head to toe): \_\_\_\_\_

❖ Do you have a **Primary Dentist**?  YES  NO

Dentist Name/Clinic: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Date of last routine dental check-up: \_\_\_\_\_

❖ Do you have a **Primary Eye Doctor**?  YES  NO

Eye Doctor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Date of last routine vision exam: \_\_\_\_\_

❖ Do you have a **Preferred Pharmacy**?  YES  NO

Preferred **Pharmacy**: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Please list any **CURRENT** health problems or conditions your child has:

Please list any **allergies** (include **food, medications**, environmental, seasonal, etc.):

Does your child see a specialist? If yes, please list condition, doctor's name, and phone number:

Please list any medications (prescribed or over-the-counter) your child takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches):

**\*\*SPECIAL NOTE: If your student needs to take any medications at school, including emergency medications (like an inhaler or Epi Pen), you must complete a CPS Administration of Medication form\*\***

Has your child had any operations, serious injuries, or hospitalizations?  No  Yes

Please provide reason and dates: \_\_\_\_\_

Has your child ever been pregnant?  No  Yes If Yes, how many living children has your child given birth to: \_\_\_\_\_

Has your child been a victim of abuse?  No  Yes

Has anything bad, scary or sad happened to your family?  No  Yes

Please explain: \_\_\_\_\_

**School Concerns: Explain any YES answers on the line provided.**

Is your child in a special class (Special Ed / IEP / 504 Plan)?  YES  NO \_\_\_\_\_

Has your child repeated a grade?  YES  NO \_\_\_\_\_

Does your child get into trouble often at school?  YES  NO \_\_\_\_\_

What are your child's grades? \_\_\_\_\_ **Is this a change?**  YES  NO

## Consent for Nitrous Oxide Sedation

Patient Name: \_\_\_\_\_

**If your child needs dental treatment, it may be beneficial or necessary to use nitrous oxide sedation in order to complete the dental treatment. Nitrous oxide relaxes children, makes them more comfortable, and gives them an all-around better experience at their dental appointment. By signing this form ahead of time it will be easier for us to do the treatment in a more timely and efficient manner. We will attempt to call you prior to using nitrous oxide on your child. Please read the following and sign at the bottom if you consent to treatment with nitrous oxide sedation. It will only be used if necessary.**

I give permission for a Cincinnati Health Department dentist to give my child nitrous oxide sedation if indicated. I understand that some side effects could occur including:

1. Nausea and vomiting we suggest that no food be eaten for at least two hours before the appointment.
2. Excessive sweating and patient may get red or flushed.
3. An unusually high amount of saliva is sometimes produced.
4. Although not common, a patient may get a sensation of having the chills.
5. In unusual circumstances, a child may become temporarily hyperactive.

The benefits include relaxation and possibly eliminating the need for local anesthetic in injections ( Novocaine ). For those patients who may need both, the use of nitrous oxide/oxygen will make the injections much easier for the patient.

At no time will the patient be asleep and at all times the patient will be given more oxygen than what is present in room air. Patients will be monitored continually by the dentist and staff, and a parent can be present as well if requested.

If you would like to be present, please make a note on the top of this form and we will be happy to schedule an appointment for you at your convenience.

I consent for my child to receive nitrous oxide sedation as deemed necessary by the dentist. I understand the dental staff will attempt to contact me prior to administering nitrous oxide.

I do not consent for my child to receive nitrous oxide sedation.



\_\_\_\_\_  
Signature (Parent/Guardian)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

# PLEASE REVIEW THE FOLLOWING INFORMATION

Program Description  
School-Based Health Center  
Cincinnati Health Department

Welcome to the School-Based Health Center. The School-Based Health Center makes medical, dental and vision care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center. If your child/adolescent develops a dental problem at school, a dentist can see your child at one of school-based dental centers located at Academy of World Languages, Withrow High School, Western Hills High School, Oylar School, Crest Smiles Shoppe, or other CHD Health Centers. If you have any questions or need help with the application, please call the School Health Program 357-2809 or contact your school nurse

## Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex; or sexual orientation.
- To have a health care assessment and plan of care and participate in your health care plan.
- To talk to your health care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow 30 days for completion of insurance or disability forms..
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency call 911 or go to the nearest emergency room. If you have an urgent issue and would like to speak with the provider on call, please call 357-7320.


## Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Cincinnati Health Department sliding fee scale. This information will be kept strictly confidential.
- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid, you can stop by our center or call 513-357-2787.

## Regarding the SHARING OF HEALTH INFORMATION:

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's regular doctor/clinic.
- The PHHC, School-Based Health Center and/or the Cincinnati Health Department (CHD) school nurse will share medical information with each other as needed.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or a community site. The mental health provider will contact you for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.
- Dates of service regarding completed dental, vision and medical care (ie. Immunizations, annual well-child check and asthma care) may be shared with your child's school if you agree and sign the Authorization form provided with this consent.

I have the right to receive or review a copy of the Notice of Privacy Practices. I acknowledge that I have been offered a copy of the Notice of Privacy Practices:

 I have received or reviewed a copy (signature and date) \_\_\_\_\_

I do not want a copy (signature and date) \_\_\_\_\_

I authorize the SBHC to call my home or cell phone number and leave a message with an adult that answers the telephone or on the voicemail pertaining to my child's medical care, including laboratory results.

**INFORMED CONSENT FOR SILVER DIAMINE FLUORIDE**

Silver diamine fluoride (SDF) is an antimicrobial liquid used to treat tooth sensitivity and to help stop tooth decay. Reapplication of SDF may be necessary to better control caries progression and is recommended every 3, 6 or 12 months but may be applied more frequently if needed. Treatment with SDF may not eliminate the need for dental fillings or crowns to repair function or esthetics. Additional procedures may incur a separate fee.

**Facts for consideration:**

- The procedure involves: 1) Proper isolation of the area and drying of affected teeth. 2) Rub a small amount of SDF on the decayed area. 3) Allow SDF to act on the tooth surface for at least 1 min, preferably up to 4 minutes. 4) Rinse tongue and oral mucosa.
- I should not be treated with SDF if: 1) I am allergic to silver or ammonia. 2) There are painful sores or raw areas on my gums or anywhere in my mouth (i.e., ulcerative gingivitis, gingivostomatitis).

**Benefits of SDF treatment:**

- It is quick, easy and painless.
- No need to numb teeth.
- It arrests 80% of cavities when applied twice yearly.
- It can help relieve tooth sensitivity.
- It is a temporary treatment option for young, fearful, or special needs that may require sedation for extensive dental care.



patients

**Risks related to SDF:**

- **The affected area will stain black permanently.** Healthy tooth structure will not discolor. Stained tooth structure can be covered with a filling or a crown in the future.
- If accidentally applied to the skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off, and it will disappear in a few days to 2 weeks.
- You may notice a very temporary metallic aftertaste.
- SDF may not work for all cavities and decay will progress with poor oral hygiene and food impaction. In that case, the affected tooth will require further treatment, which can involve a filling or a crown, root canal therapy, extraction, or referral for specialty dental care.

**Alternatives to SDF, not limited to the following:**

- No treatment, which may lead to progression of cavities, severe pain and more serious dental infection.
- Depending on the location and extend of the tooth decay as well as the level of patient behavior and cooperation, other treatment may include fluoride varnish, a filling or crown, extraction, or referral to a specialist.

*I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner. I have seen the photo displaying the discoloration of the cavity after SDF application. I consent to have Silver Diamine Fluoride (SDF) treatment with a dentist or another qualified dental staff at any dental site operated by the Cincinnati Health Department.*

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

CHD Dental Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# Authorization for Administration of Over-the Counter Medications at School

This form expires at the end of the current school year (2024-2025).

\_\_\_\_\_  
 Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ School Year \_\_\_\_\_

\_\_\_\_\_  
 Street Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after-school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

**(Circle yes or no for each medication listed below. \*Physician to complete dosage and time/frequency)**  
**Over-the-Counter Medication (Parent to Complete)      Circle      Dosage      Time/Frequency (Physician to complete)**

Over-the-Counter Medication (Parent to Complete)	Yes	No	Dosage	Time/Frequency (Physician to complete)
Acetaminophen (Tylenol) for headache, toothache or minor pain				
Ibuprofen for headache, toothache, minor pain or menstrual cramps				
Anti-itch cream or lotion				
Cough drops				
Tums (antacid)				

Is student allergic to any medications?  No  Yes, allergic to \_\_\_\_\_

Severe reactions that should be reported to the physician: \_\_\_\_\_

**Student's Provider (Physician / Nurse Practitioner / Dentist) \*Complete dosage and frequency above.**

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Emergency Phone \_\_\_\_\_

I give permission to the Cincinnati Health Department school nurse or Cincinnati Public Schools' designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Cincinnati Health Department or Cincinnati Public Schools and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

\_\_\_\_\_  
**Signature** of Parent or Guardian \_\_\_\_\_ **Date** \_\_\_\_\_

**Please Print Name** of Parent or Guardian  
**How can we reach you during school hours?**

\_\_\_\_\_  
 Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Other \_\_\_\_\_



# Authorization or Administration of Prescription Medication Form

## Parent/Provider Request for School Personnel to Give Prescription Medicine

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_ School Fax: \_\_\_\_\_

Cincinnati Board of Education policy, Section 5330, requires consent of the parent, guardian, or eligible student 18 years or older before medication (including prescription medication, inhalers, Epinephrine, etc.) can be given to a student by school personnel. The following information is necessary to comply with this policy. **Please answer all questions and return this completed form to your student's principal or school nurse.**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

<b>TO BE COMPLETED BY THE STUDENT'S PROVIDER (Physician / Nurse Practitioner / Dentist)</b>	
Name of Medication: _____	Dosage: _____
Time/Frequency: _____	How Administered: _____
Date to Begin: _____	
<b>Permission for this medication is only valid through the end of the current school year unless otherwise noted. EXCEPTION: For emergency medications for asthma, anaphylaxis, seizures or diabetes, this permission can be valid for 3 years. A provider order is required for any changes in this medication.</b>	
Date to Terminate Emergency Medication: _____ (3 years)	
Please attach an emergency action plan with procedures to be followed if emergency medication does not alleviate student's emergency.	
<b>For Epinephrine orders only:</b> I have determined that this student is capable of possessing and using this auto injector/epipen appropriately and have provided the student with training in the proper use of the auto-injector.	
Severe reactions that should be reported to the physician: _____	
Special conditions for storage of drug: _____	
Provider's Signature: _____	Date: _____
Provider's Name: _____	Emergency Phone #: _____

### TO BE COMPLETED BY THE STUDENT'S PARENT OR ELIGIBLE STUDENT

The medicine must be in pill, capsule, liquid, auto-injector or inhaler form, and must be clearly marked from the pharmacist. The label must show the student's name, medication name, dosage directions, doctor, and prescription number.

Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_

As the parent/guardian of this student (or eligible student), I give permission for the principal or designee to administer the prescribed medication. The undersigned agrees not to file or make any claim for negligence in connection with the administration or non-administration of this medicine(s) and further agrees to hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines. I will inform the school if there is a change in any of this information.

**Please check the following if applicable:**

**For Students with Asthma:**

\_\_\_\_\_ As the parent/guardian of this student, or myself, an eligible student, I authorize the student (or myself) to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school participates.

**For Students with EpiPen/Twinject/Auto Injector:**

\_\_\_\_\_ As the parent/guardian of this student, or myself, an eligible student, I authorize the student to possess and use an Epinephrine Auto-Injector, as prescribed, at the school and any activity, event, or program in which the student's school participates. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. **I will provide a backup dose of the medication to the school as required bylaw.**

**Name of Parent / Guardian / Eligible Student (please print):**  
\_\_\_\_\_

**Signature of Parent / Guardian / Eligible Student:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Primary Emergency Phone:** \_\_\_\_\_ **Secondary Emergency Phone:** \_\_\_\_\_

Cincinnati Health Department  
 School and Adolescent Health Program  
 Consent Form for 2024-2025 Seasonal Influenza Vaccine

**COMPLETE THIS FORM ONLY IF YOU WANT YOUR CHILD TO GET THE FLU VACCINE**

**A. SCHOOL NAME:** \_\_\_\_\_

STUDENT NAME (Last)	(First)	(M.I.)	GRADE/HR
DATE OF BIRTH	AGE	GENDER M / F	RACE
PHONE NUMBER			
STREET ADDRESS	CITY	STATE	ZIP
INSURANCE STATUS: <input type="checkbox"/> Medicaid <input type="checkbox"/> CareSource <input type="checkbox"/> United Healthcare Community Plan <input type="checkbox"/> Molina <input type="checkbox"/> Paramount <input type="checkbox"/> Buckeye <input type="checkbox"/> No Insurance <input type="checkbox"/> Private Insurance _____ Insurance Billing# _____ Medical Card Billing Number# _____ Child's SS# _____ *No student will be denied the flu vaccine due to inability to pay or lack of insurance			

**B. In order to determine if your child needs a booster dose, please answer this question:**

1. Did your child receive **2 doses** of seasonal flu vaccine since July 2010?    Yes    No    Unsure

**C. Please answer all of the following questions:**

	YES	NO
1. Is the student sick today with fever or respiratory illness?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the student have a serious allergy to eggs, thimerosal or another component of the flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the student ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the student ever had Guillain-Barré Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

**D. Please answer all of the following questions:**

	YES	NO
1. Does the student have a long term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
2. If the student is between the ages of 2 and 4 years old, in the past 12 months has a health care provider told you that he or she had wheezing or asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does this student have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as high dose steroids, or cancer treatment with radiation or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the person have close contact with someone who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the person on long-term aspirin or aspirin-containing therapy (for example, does the person take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the student receiving anti-viral medications?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the person pregnant or could become pregnant in the next month?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the person received any of the following vaccinations within the past 30 days? MMR, Varicella, or Flu Mist? If yes, give type and date. Recent Vaccinations: _____ Date received: _____	<input type="checkbox"/>	<input type="checkbox"/>

**E. Consent**

<p><b>CONSENT FOR VACCINATION:</b>                  I understand I will receive the <b>Flu Vaccine Information Statement</b> and be offered the <b>Cincinnati Health Department Notice of Privacy Practices</b> prior to my child receiving the vaccine.</p> <p><b>I GIVE CONSENT</b> for the student named at the top of this form to receive the Flu vaccine.</p> <p>Signature of Person/Parent/Legal Guardian _____ Date: month _____ day _____ year _____                  Print Name of Parent Legal/Guardian _____                  Parent Cell Phone Number: _____</p>
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**F: Vaccination Record (FOR ADMINISTRATIVE USE ONLY):**

Vaccine	Date Dose Administered	Route	Lot Number	Name and Title of Vaccine Administrator
2024 Seasonal Flu /	/2024	L Arm R Arm <input type="checkbox"/> IM		
Booster Dose /	/2023	L Arm R Arm <input type="checkbox"/> IM		



# Get Support with Parent Advocacy Hours

## Are you looking for support or assistance navigating CPS?

We are now offering virtual office hours with CPS' District Parent Champion, LaRonda Thomas.

Appointments are 15 minutes and give you space to ask questions, discuss any concerns or how CPS can support you and your child.

### Parent Advocacy Office Hours:

**Mondays and Wednesdays**

**10:00 a.m. - 11:00 a.m.**

**2:00 p.m. - 3:00 p.m.**

**6:00 p.m. - 7:00 p.m.**

Please contact LaRonda Thomas to schedule an appointment at [parentvoice@cps-k12.org](mailto:parentvoice@cps-k12.org) or **513-377-2167**.

*Interpreter Services available*



**PARENT VOICE**  
#activateyourvoice

## Join a Parent Organization!

Make a difference at your student's school! Join a Parent Organization today!

### School Parent Organizations give you the opportunity to:

1. Activate your voice
2. Support your students' academic and social-emotional success
3. Share your expertise
4. Build community
5. Learn and have fun!

**Contact your school's Parent Chair or School Resource Coordinator for more information**

## Create a Parent Organization at Your School!

Help us reach our goal of 65 parent organizations by 2025! Contact LaRonda Thomas, CPS Parent Champion, for information on establishing or becoming involved in a Parent Organization at your school!



To learn more visit  
<https://bit.ly/parentresources>

Email [ParentVoice@cps-k12.org](mailto:ParentVoice@cps-k12.org)  
Join our Parent Commnutiy on Facebook  
<https://bit.ly/CPSParentVoiceGroup>



## Parent Engagement Form

**Welcome New & Returning Parents, Guardians and Caregivers!**  
**Would you like to volunteer at your child's school?**

Fill out the survey online by visiting <https://bit.ly/ParentEngagementSurveySY23> or scanning the QR code.



If you complete the paper form, please return it to the main office at your child's school.

### Student Information

Name: \_\_\_\_\_

Grade: \_\_\_\_\_

School: \_\_\_\_\_

### Parent / Guardian / Caregiver Information

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Best time and /or day for volunteering:

Monday\_\_\_\_ Tuesday\_\_\_\_ Wednesday\_\_\_\_ Thursday\_\_\_\_ Friday\_\_\_\_

Please share your skills and areas of interest for volunteering. For example, tutoring, chaperone, office assistant or classroom guest speaker and topics.

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## Are you registered to vote?

Registering to vote or updating your address for voting is easy — you can go online, print a form and mail it in, or go in person to any public library or Ohio BMV.



Check your registration status or register now at  
<https://votehamiltoncountyohio.gov/register/>

To vote in the **August 6, 2024** Special Election, you must register by **July 10, 2024**.

To vote in the **November 5, 2024** Presidential Election, you must register by **October 7, 2024**.

# Voter Registration and Information Update Form

Please read instructions carefully. Please type or print clearly with blue or black ink.  
For further information, you may consult the Secretary of State's website at: [VoteOhio.gov](http://VoteOhio.gov) or call 877-SOS-OHIO (877-767-6446).

## Eligibility

You are qualified to register to vote in Ohio if you meet all the following requirements:

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

**NOTICE:** This form must be received or postmarked by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice following timely submission of this form, please contact your county board of elections.

Please see information on back of this form to learn how to obtain an absentee ballot.

**Numbers 1 and 2 below are required by law.** You must answer both of the questions for your registration to be processed.

## Identification Requirements

If you have a current Ohio driver's license or state ID card, you must provide that number on line 10. If you do not have an Ohio driver's license or state ID card, you must provide the last four digits of your Social Security number on line 10. If you have neither, please write "None."

## Residency Requirements

Your voting residence is the location that you consider to be a permanent, not a temporary, residence. Your voting residence is the place in which your habitation is fixed and to which, whenever you are absent, you intend to return. If you do not have a fixed place of habitation, but you are a consistent or regular inhabitant of a shelter or other location to which you intend to return, you may use that shelter or other location as your residence for purposes of registering to vote. If you have questions about your specific residency circumstances, you may contact your local board of elections for further information.

## Your Signature

In the area below the arrow in Box 14, please write your cursive, hand-written signature or make your legal mark, taking care that it does not touch the surrounding lines so when it is digitally imaged by your county board of elections it can effectively be used to identify your signature.

**WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE**

I am:  **Registering as an Ohio voter**  **Updating my address**  **Updating my name**

1. Are you a U.S. citizen?  Yes  No  
 2. Will you be at least 18 years of age on or before the next general election?  Yes  No  
 If you answered NO to either of the questions, do not complete this form.

3. Last Name		First Name		Middle Name or Initial		Jr., II, etc.		
4. House Number and Street (Enter new address if changed)			Apt. or Lot #	5. City or Post Office			6. ZIP Code	
7. Additional Mailing Address (if necessary)				8. County (where you live)		<b>FOR BOARD USE ONLY</b> SEC4010 (rev. 2/7/23) City, Village, Twp.  Ward  Precinct  School Dist.  Cong. Dist.  Senate Dist.  House Dist.		
9. Birthdate (MM/DD/YYYY) (required)		10. Ohio driver's license number, state ID card number, OR last four digits of Social Security number (one form of ID required to be listed or provided)		11. Phone Number (voluntary)				
12. PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION - Previous House Number and Street								
Previous City or Post Office		Previous County		Previous State				
13. CHANGE OF NAME ONLY Former Legal Name				Former Signature				
14. I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.								
Your Signature				Date (MM/DD/YYYY)				
<div style="border: 1px dashed black; height: 60px; width: 100%;"></div>								

**TO ENSURE YOUR INFORMATION IS RECEIVED,  
PLEASE DO THE FOLLOWING:**

1. Print this form.
2. Make sure all required fields are complete.
3. Sign and date your form.
4. Fold and insert your form into an envelope.
5. Mail your form to your county board of elections.

**Board of Elections – Hamilton County Ohio**  
Registration Department  
4700 Smith Rd. Cincinnati OH 45212

If you have additional questions, please call the office of the Ohio Secretary of State at 877-SOS-OHIO (877-767-6446).

**HOW TO OBTAIN AN OHIO ABSENTEE BALLOT**

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State at: [VoteOhio.gov](https://VoteOhio.gov) or by calling 877-SOS-OHIO (877-767-6446).

**OHIO VOTER IDENTIFICATION REQUIREMENTS**

Voters must bring photo identification to the polls in order to verify identity. Voters who do not provide identification will still be able to cast a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please consult the Secretary of State's website at: [VoteOhio.gov](https://VoteOhio.gov) or call 877-SOS-OHIO (877-767-6446).

**WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A  
FELONY OF THE FIFTH DEGREE.**



## 2024/2025 Calendar

August 2024						
Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

February 2025						
Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3M	4	5	6	7	8
9	10C	11	12	13	14	15
16	17P	18	19	20	21	22
23	24	25	26	27	28	

September 2024						
Su	Mo	Tu	We	Th	Fr	Sa
1	2P	3	4	5	6	7
8	9	10	11	12	13	14
15	16M	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

March 2025						
Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14Q	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

October 2024						
Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3R	4	5
6	7	8	9	10	11Q	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

April 2025						
Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14M	15	16	17	18R	19
20	21	22	23	24	25	26
27	28	29	30			

November 2024						
Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4M	5	6	7	8	9
10	11P	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27C	28P	29	30

May 2025						
Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22Q	23	24
25	26P	27	28	29	30	31

December 2024						
Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20Q	21
22	23	24	25P	26	27	28
29	30	31				

June 2025						
Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19P	20	21
22	23	24	25	26	27	28
29	30					

January 2025						
Su	Mo	Tu	We	Th	Fr	Sa
			1P	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20P	21	22	23	24	25
26	27	28	29	30	31	

July 2025						
Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4P	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

### Legend

- First day of school
- Last day of school
- Teacher Classroom Workday
- District Professional Development Day – No Students
- Building Professional Meeting Day – No Students
- Holiday / Break  
All Schools/Buildings Closed
- Holiday / Break  
Only Schools Closed
- C Teacher Conference  
Exchange Days - Schools Closed
- R Teacher Records  
Exchange Days - Schools Closed
- Weather Make-Up Day  
(if needed)
- Q** End of Quarter
- M** Midterm Week
- P** Paid Holiday \*

### Notes

171 Student Days  
191 Teacher Days  
1050 - 1137.5 Instructional Hours

\* CPS Staff: Please review payroll calendars for additional details regarding paid holidays and schedule.



## 2024-25 Calendar Dates and Details

Aug 8	Teacher Classroom Workday
Aug 9	District Professional Development Day
Aug 12	District Professional Development Day
Aug 13	Building Professional Meeting Day
Aug 14	First Day of School for Students
Sept 2	Labor Day Holiday - Schools Closed/Central Office Closed
Sept 16	Midterm Week
Sept 23	District Professional Development Day - No Students
Oct 3	Holiday/Break - Only Schools Closed - Records Day
Oct 11	End of First Quarter
Nov 4	Midterm Week
Nov 5	Election Day - Only Schools Closed
Nov 11	Veterans' Day Holiday - Schools Closed/Central Office Closed
Nov 25	Holiday/Break - Only Schools Closed
Nov 26	Holiday/Break - Only Schools Closed
Nov 27	Holiday/Break - Schools Closed – Conference Day
Nov 28	Thanksgiving Day Holiday - Schools Closed/Central Office Closed
Nov 29	Holiday/Break - Staff refer to payroll calendar
Dec 20	End of Second Quarter
Dec 23-Jan 3	Winter Recess - Only Schools Closed (10 days)
Dec 24-25	Christmas Eve and Christmas Day Holiday
Dec 31	Holiday/Break - Staff refer to payroll calendar
Jan 1	New Year's Day Holiday
Jan 6	Schools Reopen
Jan 20	Martin Luther King Jr. Day Holiday - Schools Closed/Central Office Closed
Jan 31	District Professional Development Day - No Students
Feb 3	Midterm Week
Feb 10	Holiday/Break - Only Schools Closed - Conference Day
Feb 17	Presidents' Day Holiday - Schools Closed/Central Office Closed
Mar 3	District Professional Development Day - No Students
Mar 14	End of Third Quarter
Mar 24-28	Spring Break - Only Schools Closed (5 days)
Mar 31	Schools Reopen
Apr 14	Midterm Week
Apr 18	Holiday/Break - Only Schools Closed - Records Day / Weather Make-up Day
May 22	End of Fourth Quarter - Last day for Students
May 23	Teacher Classroom Workday - Last day for Teachers
May 26	Memorial Day Holiday - Schools Closed/Central Office Closed
June 19	Juneteenth Holiday - School Closed/Central Office Closed
July 4	Independence Day Holiday - Schools Closed/Central Closed

\* All CPS staff members should refer to their payroll calendar to verify their paid holiday and breaks based on their work classification.



