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.)
- **POWER OF ATTORNEY** or **GUARDIANSHIP PAPERWORK** – if student doesn't live with parent
- Latest **IEP** or **504 PLAN** – if student receives special education services
- Copy of current **IMMUNIZATION RECORD**
- Evidence of **VISION & HEARING SCREENING** (Kindergarten only)
- **DENTAL ASSESSMENT** (Kindergarten only)

*** For more information about immunization clinics, hearing & vision screenings, dental assessments, contact the Health Department at 1-800-432-4121 or your child's physician/dentist.

The following forms need to be filled out:

- **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**
- **ORAL HEALTH ASSESSMENT 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

912 North Ohio Avenue, Gaylord, Michigan 49735
Phone: (989)731-2648 Fax: (989)731-3387
www.gaylordschools.com

650 East Fifth Street, Gaylord, Michigan 49735
Phone: (989)731-0648 Fax: (989)731-0095
www.gaylordschools.com

A Healthy Start to Kindergarten

HEALTH DEPARTMENT of Northwest Michigan

800-432-4121 nwhealth.org

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

IMMUNIZATIONS

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

HEARING & VISION SCREENINGS

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

Vision: Preschool, grades K, 1, 3, 5, 7 and 9. *Hearing: Preschool, K, grades 2 and 4.*

PHYSICAL EXAM

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

DENTAL HEALTH SERVICES

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

MEDICAID HEALTHY KIDS & MIChild

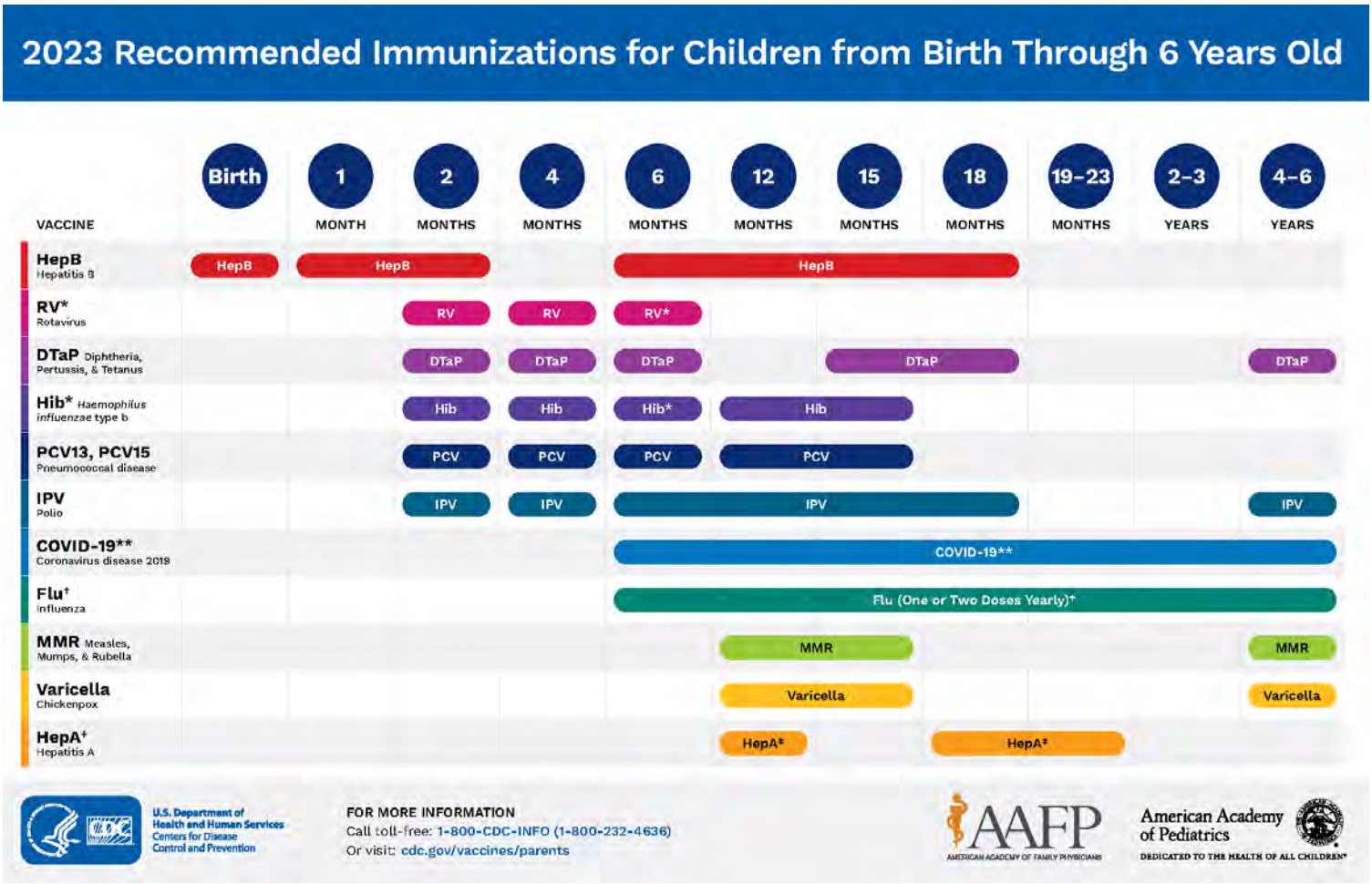
Healthy Kids provides free health insurance coverage for pregnant women and children ages 0 to 19. Coverage can include doctor visits, immunizations, prescriptions, hospital expenses, counseling and any other services normally covered by Medicaid. The income allowance for Healthy Kids is higher for pregnant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

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

WOMEN, INFANTS & CHILDREN (WIC)

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

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



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.

KINDERGARTEN ORAL HEALTH ASSESSMENT

What's New for Kindergarten?

Early detection and treatment of dental problems can help children succeed in school. That's why Michigan passed a law making dental assessments required upon entry into a child's first year of school effective with the 2024-25 school year.

KOHA

The Kindergarten Oral Health Assessment (KOHA) is a new program that is similar to Michigan's Hearing and Vision Screening Programs and is also provided by local health departments.

Questions?

Visit:
www.nwhealth.org

In The Know

What is an Oral Health Assessment?

An oral, or dental assessment is simply a look in the mouth by a dental hygienist or dentist to identify cavities, signs of disease, or other oral health problems.

Why are Oral Health Assessments Important?

Dental problems affect school attendance and test scores. Children with untreated decay often have difficulty eating, sleeping, speaking, and concentrating.

How do I get my Child's Assessment Completed?

Just like Hearing and Vision Screenings, your child can receive their dental assessment while at school. Your child's school coordinates with the Health Department of Northwest Michigan, School Oral Health Services Dental Hygienist to provide on-site, no cost screenings.

FAQ'S

What if my child already sees a dentist?

If your child sees a dentist regularly, the assessment can be performed by your dentist. You will need to download the Kindergarten Oral Assessment Form from the MDHHS website, have your dentist fill it out and return it to the school. Even if your child sees a dentist regularly, you can still have the assessment completed by the local health department while your child is at school for no cost, just like their Hearing and Vision Screenings.

Do my older children need an assessment?

The new dental assessment requirement is only for children entering kindergarten, but it is highly recommended that all children see a dentist twice a year.

What if the assessment shows my child has cavities or other dental problems?

Your child will be sent home with a letter stating any findings during their assessment. If you learn your child has a cavity from your parent letter, they will need to have the cavities treated by a dentist. A cavity does not stop growing on its own and can lead to pain and infection.

What if I don't have a dentist or can't afford one?

A list of local dental providers will be attached to your child's oral assessment parent letter. The Health Department of Northwest Michigan has a partnership with Dental Clinic's North (DCN), who ensures healthy mouths, regardless of insurance status and income.

If your child does not have dental insurance, they may be eligible for the Michigan Healthy Kids Dental Program. Healthy Kids Dental is available to children who have Medicaid and are under the age of 21.

To learn more visit:

www.michigan.gov/mdhhs/assistance programs/healthcare/childrenteens/hkdental

Learn More:
www.nwhealth.org

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

KINDERGARTEN WAIVER REQUEST FOR 2024-2025 SCHOOL YEAR

According to Michigan law, if a child residing in Gaylord Community School District is not five years of age on September 1, 2024, but will be five years of age not later than December 1, 2024, the parent or legal guardian of that child may enroll the child in kindergarten for the 2024-2025 school year if the parent or legal guardian notifies the school district in writing.

A school district that receives this written notification may make a recommendation to the parent or legal guardian as to whether the child is not ready to enroll in kindergarten due to the child's age or other factors. Regardless of the district recommendation, the parent or legal guardian retains the sole discretion to determine whether or not to enroll the child in kindergarten if the student is five years of age not later than December 1, 2024.

Student Name: _____ Date of Birth: _____

Verification of Age *(check one)*:

☐ Birth Certificate ☐ Government Record ☐ Hospital Record

☐ Court Record ☐ Citizenship Paper ☐ Other: _____
(specify)

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

1) _____

2) _____

3) _____

4) _____

_____ _____ _____
Parent/Guardian Printed Name Parent/Guardian Signature Date

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

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

Kindergarten Information Sheet

Today's Date: _____

Child's Name: _____ Birthdate: _____ Gender: _____
Name you wish your child to be called in school: _____
Mother's First Name: _____ Last Name: _____
Father's First Name: _____ Last Name: _____
Home Address: _____ City, State, Zip: _____
Mailing Address (if different): _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____
With whom does your child reside? _____
Is your child right or left handed? _____ Does your child wear glasses? __ Yes __ No
Any known allergies? ___Yes ___No
If yes, please explain:
_____

Any known health concerns? _____

___ Heart Trouble ___ Diabetes ___ Seizures ___ Asthma ___ Frequent Colds
___ Eczema ___ Earaches ___ Sore Throats ___ Fears ___ Hemophiliac
___ Bee Stings ___ Epilepsy ___ Nose Bleed ___ Hearing Problems
___ Trouble passing urine or bowel movement ___ Shortness of Breath
___ Other: _____

1. *Are there any special things about your child that we should know, such as, illness, divorce, recent move, special fears, etc. that could affect learning?*
   _____
   _____
2. *Please list any group experiences your child has participated in (STARS, Head Start, Nursery School, Daycare, Story Hour, etc). Give names and dates.*
   _____
   _____
3. *Has your child been identified for any special services such as health, speech/language, IEP or 504? ____ Yes ____ No*
   If yes, please explain.
   _____
   _____

4. *Does your child take medication on a regular basis? ____ Yes ____ No*
   If yes, what medication? _____
   Reason: _____
5. *Does your child's preschool teacher feel he/she is ready to start Kindergarten? ___ Yes ___ No*
   Please explain:

   _____

   _____
6. *Explain any responsibilities your child has at home.*

   _____

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

   _____

   _____
8. *Do you celebrate holidays and birthdays in your home? ___ Yes ___ No*
   If no, please explain:

   _____
9. *Is your child able to sit in a group setting and listen to a story for ten minutes? ___ Yes ___ No*
10. *Does your child listen without interrupting while someone else talks? ___Yes ___No*
11. *Does your child know his/her: Phone number? ___ Yes ___ No*
    Address? ___ Yes ___ No
12. *Do you have books/magazines/newspapers at home that your child reads? ___ Yes ___ No*
13. *What do you expect your child to acquire through the Kindergarten experience?*

    _____

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

    _____

    _____

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

16. *Would you be willing to volunteer in your child's classroom? ___Yes ___No*

17. *Is your child independent in the restroom? ___ Yes ___ No*
    If no, what is your plan for independence before starting Kindergarten?

    _____

    _____

4/18/22

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/GuardianPrint_____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.

STUDENT/PARENT AGREEMENT SIGNATURE PAGE

Student Name: _____ Grade: _____ Parent/Guardian Name: _____

➢ NETWORK / INTERNET ACCESS AGREEMENT FOR STUDENTS

In consideration of the privilege of using the Network, I hereby release the District, its employees, agents and individual members of the Board of Education, from any and all claims or causes of action arising out of my use or misuse of the Network or Network equipment. I agree to use the Network responsibly and to abide by the rules and regulations set forth herein and as may be added from time to time by the District.

I have reviewed the Network/Internet Access Agreement included in the District handbook with my parent or legal guardian (or I have reached the age of 18).

_____ _____

Signature of Student **Date**

The following section must be completed for all students who have not reached the age of 18.

As the Student's parents or legal guardian, I have read and agree to this Network Access Agreement and have discussed it with my son or daughter. I understand that Network access is a privilege provided for educational purposes. I understand that it is impossible for the District to restrict access to all controversial material. I hereby release the District, its employees and agents and individual members of the Board of Education from any and all claims or causes of action arising out of my use or misuse of the Network or Network equipment. In addition, I agree to indemnify the District for any fees, expenses or damages incurred as a result of my child's use or misuse of the Network or Network equipment.

_____ _____

Signature of Parent / Guardian **Date**

➢ FIELD TRIP PERMISSION

My child's class may be taking field trips and/or off campus events during the school year. When field trips require transportation, children will be transported by bus.

I give permission for my child to participate in class field trips and/or off campus events. ◯ **YES** ◯ **NO**

_____ _____

Signature of Parent / Guardian **Date**

➢ ACKNOWLEDGMENT OF STUDENT HANDBOOK

We have reviewed and read the District Parent/Student Handbook located on the GCS website. We understand the rights and responsibilities pertaining to students and agree to support and abide by the rules, guidelines, procedures, and policies of the School District. We also understand that this handbook supersedes all prior handbooks and other written material on the same subjects.

_____ _____ _____ _____

Signature of Student **Date** **Signature of Parent / Guardian** **Date**

GAYLORD COMMUNITY SCHOOLS

Directory Information Opt Out

ONLY RETURN IF YOU SELECT ANY OF THE OPTIONS BELOW

I understand that the Family Educational Rights and Privacy Act (FERPA), a federal law, allows the Gaylord Community School District to disclose designated directory information to third parties. I am choosing to have some or all of my child's directory information be withheld from this disclosure***. If you do not wish to opt-out of any of the below common uses, you do not need to return this form or take any other action.***

Please check the applicable statement below along with the information you do not wish to be shared:

____ I **DO NOT** authorize the Gaylord Community School District to share any of the following checked directory information with anyone outside of the Gaylord Community School District, with the exception of the military.

____ I **DO NOT** authorize the Gaylord Community School District to share any of the following checked directory information with anyone outside of the Gaylord Community School District, for the entire school year.

_____
Student Name

_____
Grade Level

_____
Parent/Guardian Name (Printed)

_____
Parent/Guardian Signature

_____
Date

_____ Student name (includes ALL awards, events, games, etc.)

_____ Home address

_____ Telephone number(s)

_____ Email address

_____ Grade level

_____ Date of birth

_____ Place of birth

_____ Weight/height

_____ Photograph, video or electronic images (includes ALL awards, events, games, etc.)

_____ Yearbook picture and name

_____ Most recent school/education institution attended

_____ Parent information (name, address, phone, email, etc.)

_____ Participation in officially recognized activities and sports

_____ Awards and honors received

_____ Clubs/Affiliations

_____ Printed holiday programs and/or graduation programs

_____ Newspaper articles

_____ Scholarship information

_____ PTO directories

_____ Child's work (media and internet)

MDHHS-6067, KINDERGARTEN ORAL HEALTH ASSESSMENT

Michigan Department of Health and Human Services (MDHHS)
(New 8-23)

SECTION 1 – STUDENT INFORMATION

Child's Name (Last, First, Middle)	Date of Birth
Address (Number, Street, City, Zip Code)	Home/Cell Phone Number
Parent/Guardian Name (Last, First, Middle)	Parent/Guardian Email
School Name	

SECTION 2 – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS
(Licensed dental professional must complete this section)

Date of Service	Type of Service ☐ Dental Exam ☐ Dental Assessment
Findings (Check all that apply) ☐ No findings ☐ Treated decay ☐ Untreated decay	Recommendations (Check **one**) ☐ Routine care ☐ Referral for dental treatment ☐ Referral for urgent dental care
Provider Type (Check **one**) ☐ Dentist	☐ Dental Therapist ☐ Dental Hygienist
Provider Signature	Agency/Local Health Department
Provider Name (Print)	Phone Number
Additional Comments	