

**CONSENT FOR RELEASE OF EDUCATIONAL RECORDS**

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

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

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

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

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

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

Or email to: [Michelle.Dennison@jmlocal.com](mailto:Michelle.Dennison@jmlocal.com)

Please send the following information:

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

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

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



# JACKSON-MILTON LOCAL SCHOOLS REGISTRATION FORM

ADMISSION DATE: \_\_\_\_\_ GRADE: \_\_\_\_\_ TEACHER: \_\_\_\_\_ BUS: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  Male  Female

Address of Residence: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Birth City: \_\_\_\_\_

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

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

Mother's Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Mother's Email Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Email Address: \_\_\_\_\_

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

Number of brothers: No. of older \_\_\_\_\_ No. of younger \_\_\_\_\_ Number of sisters: No. of older \_\_\_\_\_ No. of younger \_\_\_\_\_

Other children living in the household (step children etc.) \_\_\_\_\_

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

School district last attended: \_\_\_\_\_

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

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

Has the student been identified as Gifted? Yes  No

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

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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

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

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

Child lives with:

- |   |   |
|---|---|
| <input type="checkbox"/> both natural parents                 | <input type="checkbox"/> only father                  |
| <input type="checkbox"/> natural mother, step/adoptive father | <input type="checkbox"/> grandparents (legal custody) |
| <input type="checkbox"/> natural father, step/adoptive mother | <input type="checkbox"/> other (explain) _____        |
| <input type="checkbox"/> only mother                          |   |

**Part I.**

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

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

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

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

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

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

Yes  No

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

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date



# Jackson-Milton Local Schools

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

Date: \_\_\_\_\_ Grade: \_\_\_\_\_  
Teacher: \_\_\_\_\_

Student Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

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

### Primary Contact & Relationship

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

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

### If Parents Are Separated Or Divorced Who Has Custody?

Custodial Parent/Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

1. Name: \_\_\_\_\_ 3. Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Student: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
2. Name: \_\_\_\_\_ 4. Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Student: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

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

\_\_\_\_\_

**OVER**  
**SIDE 2 MUST BE COMPLETED**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

Health Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

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

Preferred Hospital: \_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_

**PLEASE SIGN ONLY ONE LINE BELOW INDICATING YOUR WISHES:**

**Part I – To Grant Consent:**

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by above named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery, unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's history including allergies, medications being taken, and any physical impairments to which a physician should be alerted are listed above.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Part II – Refusal to Consent:**

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

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



## *Proof of Residency*

Student's Name	Birth Date	Grade	Sex
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LEGAL ADDRESS

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

Signature of Parent/Guardian	Date
------------------------------	------

ADDITIONAL INFORMATIONAL/MATERIALS REQUIRED BY STATE LAW

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

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

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

- Column 2
1. Two current utility bills
  2. Two current charge statements
  3. Drivers License
  4. Tax Statement

FOR OFFICIAL USE – TO BE COMPLETED BY SCHOOL ADMINISTRATOR

APPROVED FOR ENROLLMENT \_\_\_\_\_ TEMPORARY APPROVAL \_\_\_\_\_

School	Signature of Administrator	Date
--------	----------------------------	------

State of Ohio )  
 ) :ss  
County of Mahoning )

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

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

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

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

FURTHER AFFIANT SAYETH NAUGHT:

\_\_\_\_\_  
\_\_\_\_\_, Affiant

Sworn to before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_,  
20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

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

## Appendix A: Language Usage Survey

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

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

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





(Appendix A, continued)

**\*\*\*COMPLETED BY SCHOOL EMPLOYEE\*\*\***

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

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

<p><b>Student's native language</b>                  See Language Usage Survey Question 2.                  Report for <u>all</u> students in EMIS.</p>	<p>_____</p>
<p><b>Student's home language</b>                  See Language Usage Survey Question 3.                  Report <u>only</u> for English learners in EMIS.</p>	<p>_____</p>
<p><b>Potential English learner</b>                  See Language Usage Survey Questions 2-4.</p>	<p><input type="checkbox"/> Yes. Assess the student's English proficiency.  <input type="checkbox"/> No. Do not assess the student's English proficiency.</p>
<p><b>Immigrant student status</b>                  See Language Usage Survey Questions 5-7.                  Report for <u>all</u> students in EMIS.</p>	<p><input type="checkbox"/> Yes, the student is an immigrant child.  <input type="checkbox"/> No, the child is not an immigrant child.</p>

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

\_\_\_\_\_  
 Signature of validating school employee

\_\_\_\_\_  
 Date (mm/dd/yyyy)

\_\_\_\_\_  
 Printed name of validating school employee

\_\_\_\_\_  
 Name of school or school district

Student Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

**Part 1: ETHNICITY**

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

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

**Part 2: RACIAL GROUP**

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

(W) White

People who have origins in any of the original peoples of Europe, North Africa, or the Middle East.

(B) Black or African American

Persons having origins in any of the black racial groups in Africa.

(A) Asian

Persons having origins in any of the original peoples of the Far East, Southeast Asia, or The Indian subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

(I) American Indian or Alaskan Native

Persons having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.

(P) Native Hawaiian or Other Pacific Islander

Persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

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

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

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

Hispanic/Latino  White  Black or African American

Asian  American Indian or Alaskan Native

Native Hawaiian or Other Pacific Islander

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

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



## A NOTE FROM THE SCHOOL NURSE

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

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

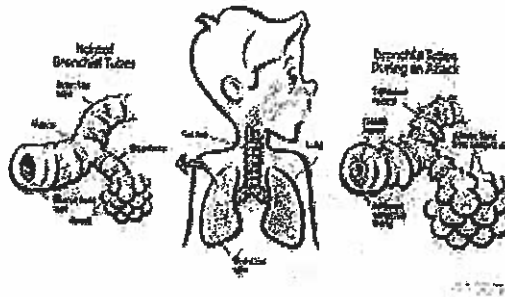
- Has a temperature of 100 degrees or more. Your child should remain at home in bed for the day and should be fever-free for 24 hours (without the aid of Tylenol or Motrin) before returning to school, as many children rebound with a temperature. This has been very frustrating lately as many children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

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

### *WHAT HAPPENS IF MY CHILD SHOULD GET SICK AT SCHOOL?*

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

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



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

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

RETURN FORM TO SCHOOL NURSE WITHOUT DELAY

EMERGENCY CARE INFORMATION FOR THE SCHOOL CLINIC

STUDENT NAME \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

Residential Parent/Guardian

Name/Relationship \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

Name/Relationship \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

Other Emergency Contacts { 1. \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_
2. \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_
3. \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_

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

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

Will student need medication available while on bus? No \_\_\_ Yes \_\_\_ Medication Name \_\_\_\_\_

Allergies No \_\_\_ Yes \_\_\_ Specify \_\_\_\_\_

Epi-Pen No \_\_\_ Yes \_\_\_ If yes, Epi-Pen Authorization Form must be completed.

Asthma No \_\_\_ Yes \_\_\_ If yes, explain severity \_\_\_\_\_

Inhaler No \_\_\_ Yes \_\_\_ If yes, Inhaler Authorization Form must be completed.

Seizures No \_\_\_ Yes \_\_\_ Emergency seizure medications? \_\_\_\_\_

Name of medications

Diabetes No \_\_\_ Yes \_\_\_ Emergency diabetic medications? \_\_\_\_\_

Name of medications

Does student take any medication regularly? No \_\_\_ Yes \_\_\_ Specify \_\_\_\_\_

Name of medications, amt taken, how often

Previous Surgeries (be specific) \_\_\_\_\_

Previous concussion/head injury & year \_\_\_\_\_

Hearing or Vision problems (be specific) \_\_\_\_\_

Behavior/emotional problems \_\_\_\_\_

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

\_\_\_\_\_
\_\_\_\_\_

# Ohio School Health History

To be used for Pre-and Elementary School

School \_\_\_\_\_  
Enrolled \_\_\_\_\_

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

## Social Service History

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

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

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

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

## Family History

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

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

## Perinatal History

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

## Developmental History

Please give the approximate age at which this child:

Walked alone \_\_\_\_\_ Spoke in sentences \_\_\_\_\_

Toilet trained \_\_\_\_\_ Dressed Self \_\_\_\_\_

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

About the same       Delayed       Advanced

## Allergies

Please list and describe allergies or reactions.

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

## Injuries, Illnesses & Hospitalizations

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

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

Does your child always wear a seatbelt while riding in automobiles

Yes       No

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

Yes       No

## Medication Information

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

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

## Health Conditions

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

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



**Behavioral History**

The child is usually:     Very active     Normally active     Rather inactive

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

- Hitting     Kicking     Biting     Fighting     Scratching

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

- Yes     No If yes, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Is this student enrolled in special education course?     Yes     No

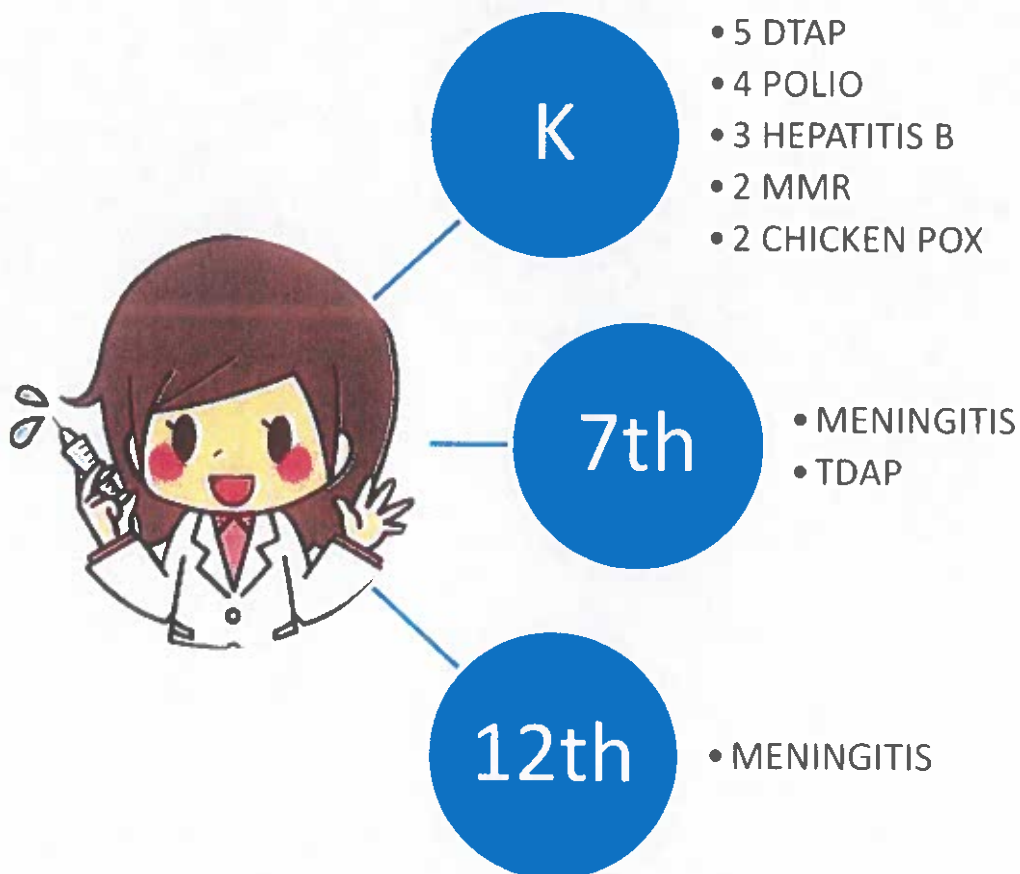


# Don't Delay, Call Today

Schedule an appointment NOW for your child's shots. Planning ahead increases the chance of getting an appointment BEFORE school starts.

**IF YOU WAIT, IT WILL BE TOO LATE!**

**OHIO REQUIRES THE FOLLOWING SHOTS FOR SCHOOL ATTENDANCE:**



## Ohio School Immunization Requirement Details

<p><b>Diphtheria, Tetanus, Pertussis</b></p>	<p><b>Grades K-12</b> Four or more doses of DTaP or DT vaccine, or any combination. If all four doses were given before the fourth birthday, a fifth dose is required. If the fourth dose was administered at least six months after the third dose, and on or after the fourth birthday, a fifth dose is not required.</p> <p><i>Recommended DTaP or DT minimum intervals for kindergarten students are four weeks between the first and second doses, and the second and third doses, and six months between the third and fourth doses and the fourth and fifth doses. If a fifth dose is administered prior to the fourth birthday, a sixth dose is recommended but not required.</i></p>
<p><b>Hep B Hepatitis B</b></p>	<p><b>Grades K-12</b> Three doses of hepatitis B vaccine. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least eight weeks after the second dose. The last dose in the series (third or fourth dose) must not be administered before age 24 weeks.</p>
<p><b>MMR Measles, Mumps, Rubella</b></p>	<p><b>Grades K-12</b> Two doses of MMR vaccine. The first dose must be administered on or after the first birthday. The second dose must be administered at least 28 days after the first dose.</p>
<p><b>IPV</b></p>	<p><b>Grades K-12</b> Three or more doses of IPV vaccine. The FINAL dose must be administered on or after the fourth birthday with at least six months between the final and previous dose, regardless of the number of previous doses.</p> <p><i>If any combination of IPV and OPV was received, four doses of either vaccine are required. Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements. Doses of OPV administered before April 1, 2016, should be counted unless specifically noted as administered during a campaign. Doses of OPV administered on or after April 1, 2016, should not be counted.</i></p>
<p><b>Varicella (Chickenpox)</b></p>	<p><b>Grades K-12</b> Two doses of varicella vaccine must be administered prior to entry. The first dose must be administered on or after the first birthday. The second dose should be administered at least three months after the first dose; however, if the second dose is administered at least 28 days after the first dose, it is considered valid.</p>
<p><b>Tdap Tetanus, Diphtheria, Pertussis</b></p>	<p><b>Grades 7-12</b> One dose of Tdap vaccine must be administered on or after the tenth birthday. Tdap can be given regardless of the interval since the last tetanus or diphtheria-toxoid containing vaccine.</p> <p><i>Children aged seven years or older with an incomplete history of DTaP should be given Tdap as the first dose in the catch-up series. If the series began at age seven to nine years, the fourth dose must be a Tdap given at age 11-12 years. If the third dose of Tdap is given at age 10 years, no additional dose is needed at age 11-12 years.</i></p>
<p><b>Meningococcal Meningococcal ACWY</b></p>	<p><b>Grades 7-11</b> One dose of meningococcal (serogroup A, C, W, and Y) vaccine must be administered on or after the 10<sup>th</sup> birthday.</p> <p><b>Grade 12</b> Two doses of meningococcal (serogroup A, C, W, and Y) vaccine. Second dose on or after age 16 years. If the first dose was given on or after the 16<sup>th</sup> birthday, only one dose is required.</p>

**CONSENT FOR RELEASE OF EDUCATIONAL RECORDS**

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

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

\_\_\_\_\_  
Moved into J-M District as resident

\_\_\_\_\_  
Attending J-M District under Open Enrollment

\_\_\_\_\_  
Court/Foster Placement to J-M School District

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

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

Fax: \_\_\_\_\_  
Phone: \_\_\_\_\_

Release records to: Jackson-Milton Elementary School IRN# 048322

14110 Mahoning Avenue  
North Jackson, Ohio 44451

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

Or email to: [Michelle.Dennison@jmlocal.com](mailto:Michelle.Dennison@jmlocal.com)

Please send the following information:

\_\_\_\_\_  
CUMULATIVE RECORDS, including grades, test scores and the last date of

\_\_\_\_\_  
attendance in your school.

\_\_\_\_\_  
HEALTH DATA, especially immunization records

\_\_\_\_\_  
PSYCHOLOGICAL REPORTS, including latest I.E.P./M.F.E.

\_\_\_\_\_  
ANY INFORMATION ON SPECIAL NEEDS

\_\_\_\_\_  
PROFICIENCY TEST RESULTS

\_\_\_\_\_  
SSID #

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

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