

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

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

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



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



Proof of Residency

Student's Name	Birth Date	Grade	Sex
----------------	------------	-------	-----

LEGAL ADDRESS

Number Street	Telephone/Work
---------------	----------------

City	State	Zip	Telephone/Work
------	-------	-----	----------------

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

Signature of Parent/Guardian

Date

ADDITIONAL INFORMATIONAL/MATERIALS REQUIRED BY STATE LAW

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

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 AFFFIANT 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.

Student Name: <i>(First Name and Last Name)</i> _____		Student Date of Birth: <i>(mm/dd/yyyy)</i> _____
Communication Preferences Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.	1. In what language(s) would your family prefer to communicate with the school? _____	
	Language Background Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.	
Prior Education Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.	2. What language did your child learn first? _____	
	3. What language does your child use the most at home? _____	
Additional Information Please share additional information to help us understand your child's language experiences and educational background.	4. What languages are used in your home? _____	
	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	
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.

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

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

Signature of validating school employee

Date (mm/dd/yyyy)

Printed name of validating school employee

Name of school or school district

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.

Ohio School Health History

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: _____

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

- ☐ SSI, Disability ☐ Healthy Start ☐ Insurance (Blue Cross/Blue Shield, HMO)
☐ LEAP ☐ Medicaid/CHIP ☐ 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 <u> </u> Lbs. <u> </u> Oz.	
Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> 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 |

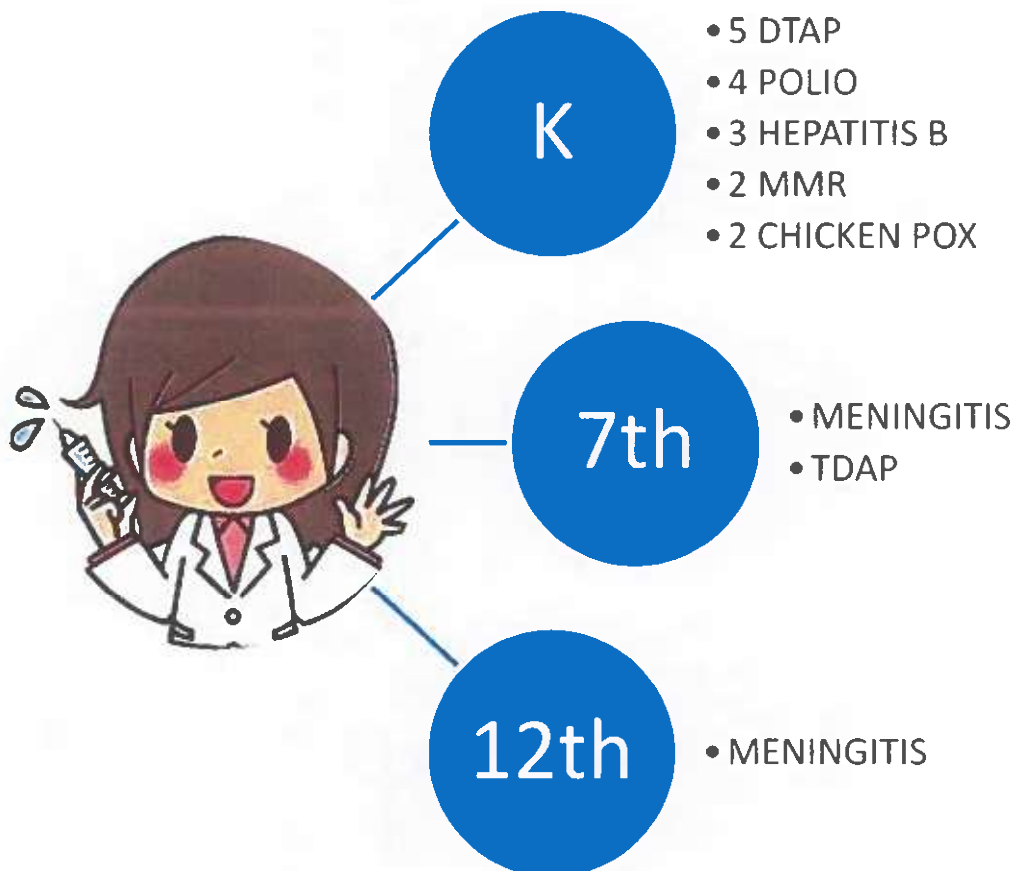


Don't Delay, Call Today

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 Immunization Summary for School Attendance, 2025-2026



Vaccine/Grade	K	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
DTaP Diphtheria, Tetanus, Pertussis	4 or more doses												
Hep B Hepatitis B	3 or more doses												
MMR Measles, Mumps, Rubella	2 doses												
Polio	3 or more doses												
Varicella (Chickenpox)	2 doses												
Tdap Tetanus, Diphtheria, Pertussis								1 dose					
MCV4 Meningococcal ACWY								1st dose				2nd dose	

Important Notes:

- Vaccine should be administered according to the most recent version of the [Recommended Child and Adolescent Immunization Schedule](#) for ages 18 years or younger or the [Catch-up immunization schedule for persons aged four months-18 years who start late or who are more than one month behind](#), as published by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.
- Vaccine doses administered less than or equal to four days before the minimum interval or age are valid (grace period). Doses administered greater than or equal to five days earlier than the minimum interval or age are not valid doses and should be repeated when age appropriate.
- If MMR and varicella are **not** given on the same day, the doses must be separated by at least 28 days with no grace period.
- For additional information, please refer to the [Ohio Revised Code 3313.67](#) and [3313.671](#) and the [Ohio Department of Health \(ODH\) Director's Journal Entry](#) regarding school immunization requirements, recommended vaccines, and exemptions to immunizations.
- Please contact the Ohio Department of Health Immunization Program at 800-282-0546 or 614-466-4643 with questions.

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? _____
