

Dear Parent/Guardian,

Thank you for registering your child with Gaylord Community Schools.

Please provide the following documents to complete the enrollment:

- **ORIGINAL BIRTH CERTIFICATE**
- **PROOF OF RESIDENCY** - must have parent/guardian name and address indicating residency (Ex. driver's license, utility bill, rent/lease agreement, property tax statement, voter's registration, mortgage document, certification from work, etc.)
- **COMPLETE IMMUNIZATION or Immunization Waiver**
- **POWER OF ATTORNEY or GUARDIANSHIP PAPERWORK** – if student doesn't live with parent
- Latest IEP or **504 PLAN** – if student receives special education services
- Evidence of **VISION & HEARING SCREENING** (Kindergarten only)  
(For more information about immunization clinics and/or hearing & vision screenings, contact the Health Department at 800-432-4121 or your child's physician)

Please fill out the following forms:

- **STUDENT INFORMATION RECORD** (Emergency Card)
- **KINDERGARTEN WAIVER** (If applicable)
- **REGISTRATION PROOF OF RESIDENCY**
- **CONSENT FOR DISCLOSURE OF IMMUNIZATION INFORMATION**
- **STUDENT INFORMATION SHEET**
- **AFFIRMATION OF PRIOR STUDENT RECORD** (Grades 1-3 / Kindergarten if previously attended school)
- **AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION** (Records Request)
- **TRANSPORTATION REGISTRATION FORM** (If applicable)
- **CONCUSSION AWARENESS ACKNOWLEDGEMENT FORM**

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

- **STUDENT/PARENT AGREEMENT SIGNATURE PAGE**
- **DIRECTORY INFORMATION OPT-OUT FORM**

Your child's school assignment will be based on the following criteria:

- Same elementary school building as sibling/s
- Residence Zone
- Class enrollment

# 2023 Recommended Immunizations for Children from Birth Through 6 Years Old

VACCINE	Birth	1 MONTH	2 MONTHS	4 MONTHS	6 MONTHS	12 MONTHS	15 MONTHS	18 MONTHS	19-23 MONTHS	2-3 YEARS	4-6 YEARS
<b>HepB</b> Hepatitis B	HepB	HepB			HepB						
<b>RV*</b> Rotavirus			RV	RV	RV*						
<b>DTaP</b> Diphtheria, Pertussis, & Tetanus			DTaP	DTaP	DTaP		DTaP				DTaP
<b>Hib*</b> Haemophilus influenzae type b			Hib	Hib	Hib*	Hib					
<b>PCV13, PCV15</b> Pneumococcal disease			PCV	PCV	PCV	PCV					
<b>IPV</b> Polio			IPV	IPV	IPV						IPV
<b>COVID-19**</b> Coronavirus disease 2019					COVID-19**						
<b>Flu*</b> influenza					Flu (One or Two Doses Yearly)*						
<b>MMR</b> Measles, Mumps, & Rubella						MMR					MMR
<b>Varicella</b> Chickenpox						Varicella					Varicella
<b>HepA*</b> Hepatitis A						HepA*		HepA*			



U.S. Department of Health and Human Services  
Centers for Disease Control and Prevention

FOR MORE INFORMATION  
Call toll-free: 1-800-CDC-INFO (1-800-232-4636)  
Or visit: [cdc.gov/vaccines/parents](https://cdc.gov/vaccines/parents)



American Academy of Pediatrics  
DEDICATED TO THE HEALTH OF ALL CHILDREN®

**FOR AN APPOINTMENT AT ANY OF THE FOLLOWING LOCATIONS, PLEASE CALL 1-800-432-4121**

<b>BELLAIRE</b>	HEALTH DEPARTMENT – 209 Portage Dr.
<b>BOYNE CITY</b>	BOYNE CITY EDUCATION CENTER – 321 S. Park St.
<b>CHARLEVOIX</b>	HEALTH DEPARTMENT – 220 W. Garfield
<b>GAYLORD</b>	HEALTH DEPARTMENT – 95 Livingston Blvd.
<b>MANCELONA</b>	HEALTH DEPARTMENT – 205 Grove St.
<b>PETOSKEY</b>	HEALTH DEPARTMENT – 3434 M-119, Suite A
<b>PELLSTON</b>	HORNET HEALTH CENTER – 172 Park St.

*This institution is an equal opportunity provider.*

# 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)		
<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> African American	<input type="checkbox"/> American Indian / Alaska Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Native Hawaiian / Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic / Latino

**LANGUAGE SPOKEN AT HOME:**(select all that apply)  English  Spanish  Other: (specify) \_\_\_\_\_

**STUDENT LIVES WITH:** (check one):

<input type="checkbox"/> Both Parents	<input type="checkbox"/> Mother Only	<input type="checkbox"/> Father Only	<input type="checkbox"/> Foster Parents	<input type="checkbox"/> Other (specify below)
<input type="checkbox"/> Joint Custody	<input type="checkbox"/> Mother / Step-Father	<input type="checkbox"/> Father / Step-Mother	<input type="checkbox"/> Host Family	_____
<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Mother / Other	<input type="checkbox"/> Father / Other	<input type="checkbox"/> Adult Student	_____

**STUDENT'S RESIDENCE IS:** (check one)

<input type="checkbox"/> Single Family Dwelling	<input type="checkbox"/> More than 1 family in house	<input type="checkbox"/> Motel / Car / Campsite
<input type="checkbox"/> With Friends / Family (other than parent/guardian)	<input type="checkbox"/> Shelter	<input type="checkbox"/> 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): <input type="checkbox"/> YES <input type="checkbox"/> NO	Lives with Student (select one): <input type="checkbox"/> YES <input type="checkbox"/> 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

## REGISTRATION PROOF OF RESIDENCY

**Proof of residency Submitted:**

- |  |   |
|--|---|
| <input type="checkbox"/> Driver's license<br><input type="checkbox"/> Lease / Rental agreement<br><input type="checkbox"/> Utility bill for the current month<br><input type="checkbox"/> Property Tax Bill<br><input type="checkbox"/> Mortgage Statement | <input type="checkbox"/> Proof of residency from the County Registrar of Voters<br><input type="checkbox"/> Current vehicle registration showing residency address<br><input type="checkbox"/> Letter from parent's employer on company letterhead<br><input type="checkbox"/> Copy of money order for rent payment<br><input type="checkbox"/> 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



## ***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: \_\_\_\_\_





**Gaylord Community Schools**  
**First Through Third Grade 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: \_\_\_\_\_

With whom does your child reside? \_\_\_\_\_

Home Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

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

After School Plan:  Pick up by MOM  DAD  LEGAL GUARDIAN  Other \_\_\_\_\_

Ride the bus

Latchkey

Joint custody (court paperwork must be provided)

pick up by MOM every MON TUES WED THURS FRI

pick up by DAD every MON TUES WED THURS FRI

Additional details: \_\_\_\_\_

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

(We cannot restrict a parent without legal documentation on file at the school)

1. Is your child right or left-handed? \_\_\_\_\_

2. Does your child wear glasses?  Yes  No

3. Any known allergies?  No  Yes If yes, please explain: \_\_\_\_\_

4. Any known health concerns? \_\_\_\_\_

5. Has your child been identified for any special services such as health, speech/language, or IEP?

No  Yes If yes, please explain: \_\_\_\_\_

6. Does your child take medication on a regular basis?  Yes  No

If yes, what medication? \_\_\_\_\_

Reason: \_\_\_\_\_

7. 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?

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

8. Please list any social groups your child has participated in (GCS Preschool, STARS, Head Start, nursery school, daycare, story hour, etc). Give names and dates.

---

---

9. How many hours of screen time does your child have per day? \_\_\_\_\_

10. What time does your child go to bed? \_\_\_\_\_

Do you have a bedtime routine? \_\_\_\_\_ Yes \_\_\_\_\_ No

11. What else would you like your child's teacher to know about your child?

---

---

**FOR 2<sup>ND</sup> and 3<sup>RD</sup> GRADE STUDENTS ONLY**

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

---

---

13. Explain any responsibilities your child has at home.

---

---

14. What are some favorite things your child likes to do?

---

---

15. Do you celebrate holidays and birthdays in your home? \_\_\_ Yes \_\_\_ No

If no, please explain: \_\_\_\_\_

16. Is your child able to sit in a group setting and listen to a story for 25-30 minutes? \_\_\_ Yes \_\_\_ No

17. Does your child listen without interrupting while someone else talks? \_\_\_ Yes \_\_\_ No

18. Does your child know his/her: Phone number? \_\_\_ Yes \_\_\_ No

Address? \_\_\_ Yes \_\_\_ No

19. Do you read with your child? \_\_\_ Yes \_\_\_ No

If yes, how often? \_\_\_\_\_

20. What do you expect your child to acquire through his/her educational experience?

---

---



**AFFIRMATION OF PRIOR STUDENT RECORD**

[NOT a request for records]

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

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

Previous School District: \_\_\_\_\_

➤ **DISCIPLINE**

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

NO

YES

➤ **SPECIAL EDUCATION SERVICES / Section 504**

My child received the following services:

SPECIAL EDUCATION SERVICES

Section 504

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

\_\_\_\_\_  
District Representative

\_\_\_\_\_  
Date

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

From: \_\_\_\_\_  
(name of previous school)

Please check one:

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

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

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

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

\_\_\_\_\_  
Signature of Sending District Administrator or Designee

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date



**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

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

School Transferring From: \_\_\_\_\_ School District: \_\_\_\_\_

Previous School Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

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

<input type="checkbox"/>	COMPLETE CUMULATIVE	<input type="checkbox"/>	TRANSCRIPT	<input type="checkbox"/>	CURRENT MET, IEP, 504 Plan	<input type="checkbox"/>	Confidential Files (IEPC)
<input type="checkbox"/>	BIRTH CERTIFICATE	<input type="checkbox"/>	WITHDRAWAL GRADES	<input type="checkbox"/>	MEDICAL FILE	<input type="checkbox"/>	Psychological & Diagnostic Reports
<input type="checkbox"/>	IMMUNIZATION RECORD	<input type="checkbox"/>	CURRENT SCHEDULE	<input type="checkbox"/>	SOCIAL WORKER REPORTS	<input type="checkbox"/>	DISCIPLINE RECORD

Has the above child received special education services?     NO     YES

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

If marked yes, area(s) services provided: \_\_\_\_\_

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

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

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

UIC No. \_\_\_\_\_ First Date of Attendance: \_\_\_\_\_

\_\_\_\_\_  
Signature of GCS Administrator

**PLEASE FORWARD STUDENT RECORDS TO SCHOOL INDICATED BELOW:**

Date Request Sent: \_\_\_\_\_

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



# Gaylord Community Schools Transportation Registration Form



Transportation questions please call: (989) 705-3022

**Return registration forms to your students' school building during school days.  
During the summer months, please return to the Board of Education Office- 615 S. Elm Avenue.**

Date: \_\_\_\_\_  New  Change  Moved

⊗ New enrollment registration forms must be completed and returned to the Registrars' Office.

⊗ Families with multiple students need to submit only one form.

⊗ It may take Transportation Dept. up to 5 school days to arrange for busing upon receiving this form.

⊗ More processing time may be necessary during the new school year registration period.

Student Name	School	Grade	Gender

**Bus Stop will be at or closest to the students address. We can accommodate ONLY one Pick Up and ONLY one Drop Off location**

**AM Pick Up** (check one)  Home  Day Care  Other Contact Name \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

**PM Drop Off** (check one)  Home  Day Care  Other Contact Name \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

**\*Signature of Parent/Guardian\*Print \_\_\_\_\_ Sign \_\_\_\_\_**

**Email: \_\_\_\_\_ Phone: \_\_\_\_\_**



Please Fill Out Top Half

**Joint Custody/Shared Parenting Only** If student will be transported to/from a destination other than listed above, please indicate below. **A copy of court papers must be provided with registration form.**

Parent Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

**AM Pick Up** (check one)  Home  Day Care  Other Contact Name \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

**PM Drop Off** (check one)  Home  Day Care  Other Contact Name \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

**Email: \_\_\_\_\_ Phone: \_\_\_\_\_**

**.....It is the responsibility of the shared custody parents to inform students school of bus schedule weekly.....**

Route # \_\_\_\_\_ Stop \_\_\_\_\_ BUS START \_\_\_\_\_

Route # \_\_\_\_\_ Stop \_\_\_\_\_ \_\_\_\_\_

Route  PS  Parent Noti.  Attached  Driver  Notes: \_\_\_\_\_





## UNDERSTANDING CONCUSSIONS

### Educational Material for Parents and Students

(Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE), National Athletic Trainers Association

Some Common Symptoms				
Headache	Balance Problems	Sensitivity to Noise	Poor Concentration	Not "Feeling Right"
Pressure in the Head	Double Vision	Sluggishness	Memory Problems	Feeling Irritable
Nausea/Vomiting	Blurry Vision	Haziness	Confusion	Slow Reaction Time
Dizziness	Sensitivity to Light	Fogginess	"Feeling Down"	Sleep Problems
		Grogginess		

### WHAT IS A CONCUSSION?

A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning for a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to activity on the day of the injury and not until a health care professional says they are okay to return to activity.

### IF YOU SUSPECT A CONCUSSION:

1. **SEEK MEDICAL ATTENTION RIGHT AWAY**-A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.
2. **KEEP YOUR STUDENT OUT OF ACTIVITY**-Concussions take time to heal. Don't let the student return to activity the day of the injury and not until a health professional says it is okay. A student who returns to activity too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal.
3. **TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION(S)**-Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

### SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused or has trouble with homework or school assignments
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Appears fatigued
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior or personality changes

### CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. If a student sustains a bump, blow or jolt to the head or body and the following danger signs are present, **immediate medical attention** should be sought at the closest emergency department.

• One pupil larger than the other	• Repeated vomiting or nausea	• Becomes increasingly confused or agitated	• Is drowsy and cannot be awakened
• Slurred speech	• Has unusual behavior	• A headache that gets worse	• Convulsions or seizures
• Weakness, numbness or decreased coordination	• Cannot recognize people or places	• Loses consciousness (even briefly)	

### 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](http://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.