

Dear Parent/Guardian,

Thank you for registering your child with Gaylord Community Schools.

Please provide the following documents to complete the enrollment:

- **ORIGINAL BIRTH CERTIFICATE**
- **PROOF OF RESIDENCY** - must have parent/guardian name and address indicating residency (Ex. driver's license, utility bill, rent/lease agreement, property tax statement, voter's registration, mortgage document, certification from work, etc.)
- **POWER OF ATTORNEY** or **GUARDIANSHIP PAPERWORK** – if student doesn't live with parent
- Latest **IEP** or **504 PLAN** – if student receives special education services
- Copy of current **IMMUNIZATION RECORD**
- Evidence of **VISION & HEARING SCREENING** (Kindergarten only)
- **DENTAL ASSESSMENT** (Kindergarten only)

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

The following forms need to be filled out:

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

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

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

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

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

A Healthy Start to Kindergarten

Entering school is a major milestone. We can help your child have a healthy start with:

IMMUNIZATIONS

Parents of kindergarten students must show proof of having had the required childhood immunizations by the first day of school. If you wish to waive immunizations for religious or philosophical reasons, you must make an appointment at the local health department for waiver education. Students with medical conditions that may impact immunizations must see their doctor to get the required form. The health department provides FREE immunizations to children without health insurance and bills Medicaid Healthy Kids, MICHild, and several private insurances.

HEARING & VISION SCREENINGS

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

Vision: Preschool, grades 1, 3, 5, 7 and 9.

Hearing: Preschool, K, grades 2 and 4.

PHYSICAL EXAM

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

ORAL HEALTH SCREENINGS

New for 2024, Michigan passed a law that requires children enrolling into their first year of school to have an oral health assessment within 6 months of starting Kindergarten. The Michigan Kindergarten Oral Health Assessment Program (KOHA) helps ensure each student is healthy and ready for a successful school year. HDNW representatives will visit your child's school during the Kindergarten year to provide screenings with a Michigan Licensed Dental Hygienist, or parents/guardians may bring the [Official Assessment Form](#) to your child's home dental office for completion and return it to the school. HDNW partners with Dental Clinics North to ensure healthy mouths, regardless of insurance status and income. Call 1-877-321-707 to schedule an appointment.

MEDICAID HEALTHY KIDS & MICHild

Healthy Kids provides free health insurance for pregnant women and children ages 0 to 19. Coverage can include doctor visits, lab fees, prescriptions, hospital expenses, and other services. The income allowance for is higher for pregnant women and infants up to their first birthday is \$4,875 per month for a family of 4 and \$4,000 for a family of 4 with children ages 1 to 19.

MICHild is a health insurance program for uninsured children ages 0-19. A family of 4 with a monthly income less than \$5,300 is eligible. Doctor visits, immunizations, prescriptions, dental, vision & hospital care are covered. The cost is \$10 per child with a maximum of \$20 per family. If you have another insurance with high deductibles, you may qualify for MICHild.

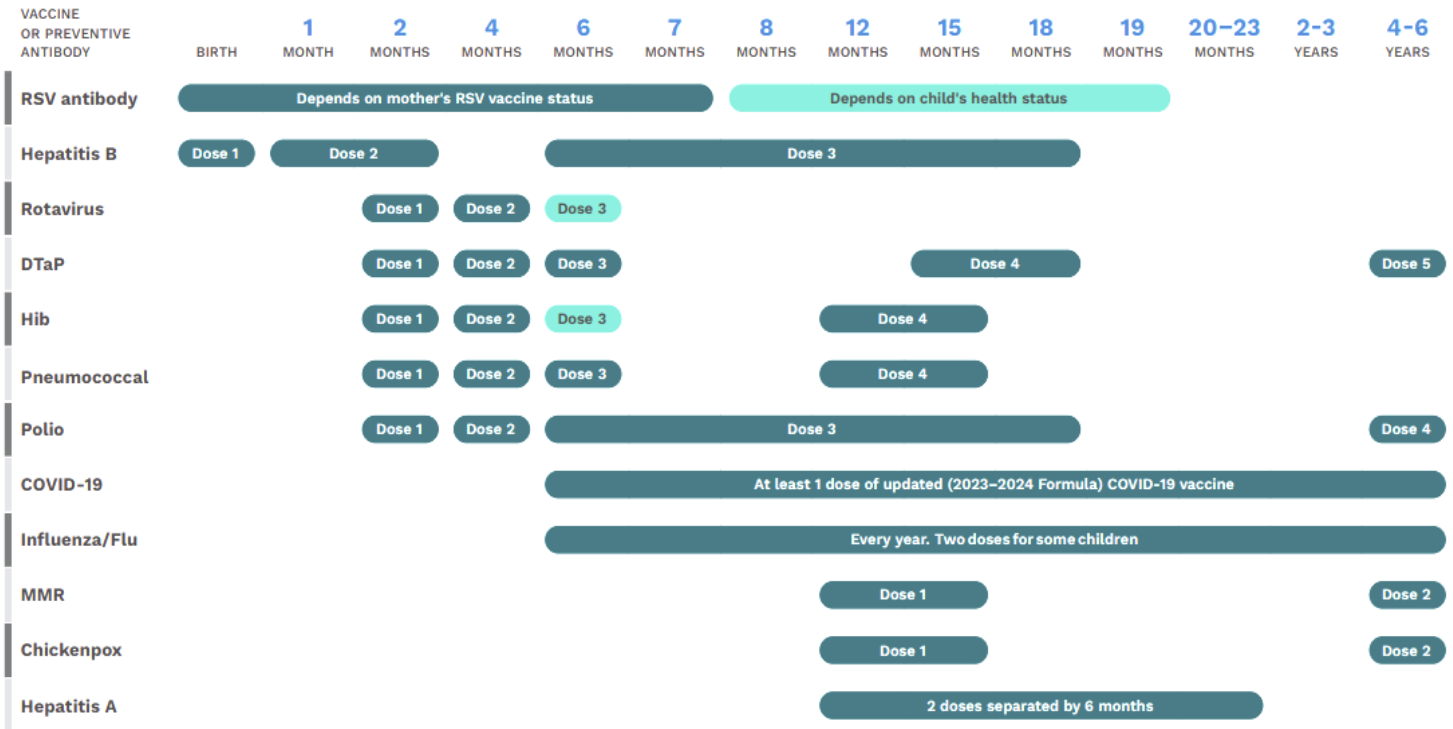
WOMEN, INFANTS AND CHILDREN (WIC)

The WIC program is a food and nutrition program for pregnant women, breastfeeding women, women who have had a baby in the last six months, infants, and children up to age five. All WIC clients, parents, and their caregivers are offered nutrition education. WIC provides free foods such as: milk, yogurt, juice, cheese, eggs, cereal, peanut butter, fruits and vegetables, juice, tuna, infant formula, and infant cereal. A family of 4 with a monthly income less than \$4,625 may be eligible.

For more information on these programs, to schedule an appointment, or for help applying for health insurance, call us at 1-800-432-4121.

No child is denied immunizations due to an inability to pay. Contact your child's primary care provider or HDNW if you have any questions or would like to schedule an appointment. This institution is an equal opportunity provider and employer.

2024 CDC Recommended Immunizations for Infants and Children Birth to 6 Years



KEY

- All children should be immunized at this age.
- Some children should get this vaccine or preventative antibody at this age.

FOR AN APPOINTMENT AT ANY OF THESE LOCATIONS, PLEASE CALL 1-800-432-4121.

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



Did You Know?

Being prepared for school starts with a dental screening. Kindergarteners are now required to have one.

A healthy mouth is important. Dental problems can prevent children from doing well in school. **Kindergarteners are required to have a dental screening** so that any problems can be fixed and they attend school ready to learn.



Cavities are common. Tooth decay (cavities) is the most common chronic disease in children.



Cavities can cause pain. Pain can make it hard for children to pay attention in school, prevent them from eating well and keep them awake at night. All of this can affect their ability to learn.



Dental problems affect attendance and grades. Children with dental problems miss more school than children with good dental health.

Facts About Kindergarten Dental Screenings

- 1 It's easy to get your child screened.** Local health departments provide the screenings (oral health assessments) before the start of kindergarten at places like preschools, school registration events, community events and in schools during the kindergarten school year. Check with your school or the local health department for a schedule.
- 2 The screening is free.** There is no cost to you if the local health department does the screening. Check with the school to find out when the health department will be at the school, or call the health department to check when and where they will be screening.
- 3 A dental screening is simple and fast.** A dental professional will look into your child's mouth and note what they see on the screening form. No treatment is done. It's simply a quick look in the mouth. They will let you know if your child needs to see a dentist.
- 4 Help is available.** The local health department can help you find a dentist if you don't have one. Your child may be able to enroll in the Michigan Healthy Kids Dental Program if they don't have insurance. For information about Healthy Kids Dental, visit www.michigan.gov/mdhhs/assistance-programs/healthcare/childrenteens/hkdental.

Common Questions

How will my child benefit from having a dental screening?

Dental problems can cause pain and make it difficult for children to pay attention in school, prevent them from eating and sleeping well, and can even affect their ability to speak and socialize. All of this can affect a child's ability to learn and do well in school. Children benefit from having a dental screening to check for any dental problems that need to be fixed so that they are ready to learn.

Where can I get the screening done?

Local health departments provide the screenings before the start of kindergarten at places like preschools, school registration events, community events and in schools during the kindergarten school year. Check with your child's school to find out when the health department will be screening at the school or call your local health department to check their schedule. **There is no cost to you if the screening is done by the local health department.** Or, you can take your child to your family dentist to have the screening done there.

Do my older children need a dental screening, too?

The dental screening requirement is only for kindergarteners, but it is recommended that all children see a dentist at least once a year.

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

The local health department can provide you with a list of dental providers in your area. Check the Michigan Oral Health Directory for a list of low- and no-cost dental providers by county: <https://www.michigan.gov/mdhhs/adult-child-serv/childrenfamilies/familyhealth/oralhealth>. If your child does not have dental insurance, they may be eligible for the Michigan Healthy Kids Dental Program: www.michigan.gov/mdhhs/assistance-programs/healthcare/childrenteens/hkdental.



For More Information:

MDHHS-KOHA@michigan.gov



The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

GAYLORD COMMUNITY SCHOOLS 2025-2026 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



KINDERGARTEN WAIVER REQUEST FOR 2025-2026 SCHOOL YEAR

According to Michigan law, if a child residing in Gaylord Community School District is not five years of age on September 1, 2025, but will be five years of age not later than December 1, 2025, the parent or legal guardian of that child may enroll the child in kindergarten for the 2025-2026 school year if the parent or legal guardian notifies the school district in writing.

A school district that receives this written notification may make a recommendation to the parent or legal guardian as to whether the child is not ready to enroll in kindergarten due to the child’s age or other factors. Regardless of the district recommendation, the parent or legal guardian retains the sole discretion to determine whether or not to enroll the child in kindergarten if the student is five years of age not later than December 1, 2025.

Student Name: _____ Date of Birth: _____

Verification of Age (*check one*):

- Birth Certificate Government Record Hospital Record
- Court Record Citizenship Paper Other: _____
(specify)

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

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Parent/Guardian Printed Name

Parent/Guardian Signature

Date

REGISTRATION PROOF OF RESIDENCY

Proof of residency Submitted:

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

Today's Date: _____

Child's Name: _____ Birthdate: _____ Gender: _____

Name you wish your child to be called in school: _____

Mother's First Name: _____ Last Name: _____

Father's First Name: _____ Last Name: _____

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? _____

Heart Trouble Diabetes Seizures Asthma Frequent Colds

Eczema Earaches Sore Throats Fears Hemophiliac

Bee Stings Epilepsy Nose Bleed Hearing Problems

Trouble passing urine or bowel movement Shortness of Breath

Other: _____

5. Has your child been identified for any special services such as health, speech/language, IEP or 504?

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 group experiences your child has participated in (GCS Preschool, STARS, Head Start, Nursery School, Daycare, Story Hour, etc). Give names and dates.

9. Does your child's preschool teacher feel he/she is ready to start Kindergarten? Yes No
Please explain: _____

10. Explain any responsibilities your child has at home.

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

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

13. Is your child able to sit in a group setting and listen to a story for ten minutes? Yes No

14. Does your child listen without interrupting while someone else talks? Yes No

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

16. What do you expect your child to acquire through the Kindergarten experience?

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



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 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: _____



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 <https://www.cdc.gov/heads-up/>.

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.

MDHHS-6067, KINDERGARTEN ORAL HEALTH ASSESSMENT

Michigan Department of Health and Human Services (MDHHS)

(New 8-23)

SECTION 1 – STUDENT INFORMATION

Child's Name (Last, First, Middle)

Date of Birth

Address (Number, Street, City, Zip Code)

Home/Cell Phone Number

Parent/Guardian Name (Last, First, Middle)

Parent/Guardian Email

School Name

SECTION 2 – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

(Licensed dental professional must complete this section)

Date of Service

Type of Service

Dental Exam

Dental Assessment

Findings (Check all that apply)

No findings

Treated decay

Untreated decay

Recommendations (Check **one**)

Routine care

Referral for dental treatment

Referral for urgent dental care

Provider Type (Check **one**)

Dentist

Dental Therapist

Dental Hygienist

Provider Signature

Agency/Local Health Department

Provider Name (Print)

Phone Number

Additional Comments

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

