BACK-TO-SCHOOL PACKET

2025-2026
School Year

cps-k12.org

Back-to-School Packet - Table of Contents

Page **Form**

Dear CPS Families,

Welcome back!

We're excited to kick-off the school year with you! Please find the 2025-2026 Back-to-School packet enclosed. **All back-to-school forms are available digitally on FOCUS**.

Collecting back-to-school information online is preferred to ensure fewer errors. Online forms are available in Spanish, French, and Arabic. Benefits to filling out the forms online include:

- You only need to check and update existing information
- Ensures student information is not duplicated

To access online documents, create an account on FOCUS and search for your child with their FOCUS ID number, first and last name, and date of birth.

If you need help, your child's school has staff that are trained to use the Online Registration System.

If you fill out forms digitally, you do not need to fill out paper forms. However, since many families prefer paper forms, inside this document, you will find all paper forms families are required to fill out, including:

- Health history and consent forms
- CPS' Mobile Device Agreement and Acceptable Use Policy
- Parent Involvement Survey
- Positive Behavior Intervention Supports
- CPS District Calendar

Families are also responsible for understanding Emergency Weather Procedures, which can be found on our website at https://www.cps-k12.org/our-students/severe-weather-procedures.

To get a copy of the forms in Spanish, French or Arabic, please contact your school.

If you would like to register a student for preschool, please contact early childhood education at (513) 363-0240 or visit https://www.cps-k12.org/our-district/preschool.

Thank you, and we look forward to a great school year!

Students with Disabilities

Cincinnati Public Schools is conducting an Intensive Awareness Campaign in accordance with the requirements of the Individuals with Disabilities Education Improvement Act (IDEIA 2004), the Ohio Administrative Code, the Ohio Revised Code, and the Operating Standards for Ohio Educational Agencies Serving Children with Disabilities.

Public school districts and the Ohio Department of Education are trying to **identify children with disabilities, from birth through age 21**, who may need special education and related services.

For children birth to age 3, a disability means an established condition known to result in either a developmental delay or a documented developmental delay.

For children ages 3 through 5, a disability means a child has a documented deficit in <u>one or more</u> of the following developmental areas:

- Communication
- Vision
- Hearing
- Motor skills
- Social emotional/behavioral functioning
- Self-help skills
- Cognitive development

For school-age children, a disability means a child has been identified as having <u>one or more</u> of the following conditions:

- Autism
- Deaf-blindness
- Hearing impairment (including deafness)
- Multiple disabilities
- Orthopedic impairment
- Other health impairment
- Specific learning disability
- Speech or language impairment
- Traumatic brain injury
- Visual impairment (including blindness)
- Intellectual disabilities
- Emotional disturbance

Your public school offers:

- Evaluation for all children with suspected disabilities, birth through age 21
- Education for all children with disabilities ages 3 through 21 years

When school staff is notified about a child who is suspected of having a disability:

- The child's parents are contacted and informed of their rights, as required by the Individuals with Disabilities Education Improvement Act (IDEIA 2004), the Ohio Revised Code, and the State Board of Education's Operating Standards for Ohio's Schools Serving Children with Disabilities.
- Arrangements are made to review all information and documentation pertaining to the suspected disability.

If you know a child who is suspected of having a disability and is not being served, tell staff at the child's school or contact CPS' Student Services Department, (513) 363-0280.

Districtwide Discipline Policy

Positive Behavior Intervention Supports

- There is a district-wide Code of Conduct for students.
- The Code of Conduct is updated annually and available for review on CPS' website: **www.cps-k12.org/codeofconduct**

Cincinnati Public Schools strives to create a Positive School Culture in all our schools, aimed at creating a safe and orderly environment that keeps students in school and engaged in learning.

Part of this Positive School Culture is a district-wide **Code of Conduct** that provides clear and explicit expectations for student behavior, specifies guidelines for teaching social skills to students, describes methods to help correct behavior and outlines the consequences for misbehavior.

In addition to the Code of Conduct, each school is required to develop its own Positive Behavior Intervention Supports Plan through its Positive Behavior Intervention Supports Committee. This plan must include a range of options that teach behavior expectations to students. Schools must communicate this plan to parents and students. Parents should know and understand the Positive Behavior Intervention Supports Plan at their children's schools.

Searches of Student and Property

Students will be subject to searches by metal detectors and/or by hand on a random basis, or with reasonable suspicion, by district administrators or security personnel.

The district may search: A student's outer clothing, pockets, book bags or other property; a student's locker; a vehicle driven to school by a student and parked on school property.

Students have no expectation of privacy in cell phones or other electronic devices brought to school. If there is reasonable suspicion that a search will reveal a violation of school rules, cell phones and other electronic devices may be confiscated and searched, including searching calls, e-mails, contacts, texts, and other communications or Internet access.

Students will be treated with respect during a search. Any student failing to cooperate during a search will be subject to discipline under the CPS Code of Conduct.

The Cincinnati Public School District is not responsible for damaged, lost or stolen personal items.

Dear CPS Families, Parents & Guardians,

Providing our CPS students and staff with a safe educational environment remains one of our top priorities. As a part of an April 2022 School Board resolution, we are encouraging our families to implement secure firearm storage at home to ensure children don't have access and/or bring a gun to school. A firearm stored safely at home is the first step. We have partnered with the "Be Smart For Kids" program to provide you with key information, statistics, and the ability to get a gun lock.

BE SMART

Secure all guns in your homes and vehicles;
Model responsible behavior around guns;
Ask about unsecured guns in other homes;
Recognize the role of guns in suicide;
Tell your peers to Be SMART

Studies of school-based gun violence point to the same significant point for intervention: addressing students' unauthorized access to guns in the home. One recent study of targeted school violence incidents from 2008 to 2017 found that 76% of the firearms were obtained from the home of a parent or close relative.

What's more, unsecured guns in the home pose a risk to students *outside* school. Firearms are now the leading cause of death among children in the U.S. Every year, nearly 350 children under the age of 18 unintentionally shoot themselves or someone else. Distressingly, almost 40% of child gun deaths are suicides—nearly 700 child gun suicides annually (pre-pandemic). In most incidents, the gun used was one that belonged to someone in the student's home.

4.6 million American children live in homes with guns that are both loaded and unlocked.

One study found that 87% of kids know where their parents' guns are kept, and 60% have handled them. Research shows that secure firearm storage practices are associated with up to an 85% reduction in the risk of self-inflicted and unintentional firearm injuries among children and teens. Storing firearms securely protects any child in your home as well as students throughout the school district and community.

As an additional measure to ensure our parents are informed and aware about secure firearm storage, our school staff will share this information while registering their children for the 2024-2025 school year and confirm this within our student information system.

You can also learn more about secure firearm storage, talking to your children about guns, and facts and resources on child firearm suicide at **BeSMARTforKids.org.** Please take the necessary steps in protecting your family, community, and schools – 'Be Smart' and secure your firearms.

Yours in Service,

Shauna Murphy
Superintendent

Update to the Meal and Educational Benefits Application

Dear CPS Families,

During the pandemic, free breakfast and lunch meals were provided to all students regardless of income verification.

For Fall 2025, breakfast will continue to be provided at no cost to all students, but expired federal waivers as of July 1, 2022 will require parents/guardians with children attending the below three CPS schools to complete a Meal & Educational Benefits Application to qualify for free lunch:

- Hyde Park School
- Kilgour School
- Walnut Hills High School

Paid meals will be $1.75 at elementary schools and $2.00 at secondary schools.

Parents/guardians at these three schools may access and fill out the online application available on the CPS webpage or complete a paper application at your child's school.

For more information about our Student Dining Services and Free and Reduced Meal programs, please visit: www.cps-k12.org/studentdining.

Request to Restrict Privacy Information and Photos/Video

Federal and Ohio laws prohibit Cincinnati Public Schools (CPS) from publicly releasing student information, photos and video/audio without authorization, except for designated "Directory Information." Under Ohio public records law, CPS is required upon request to provide the Directory Information to any member of the public who requests it. Per **Board Policy No. 8330**, CPS defines Directory Information as the following:

> A student's name, school, grade level, parent-guardian's name, home address, telephone number, email address, participation in officially recognized activities and sports, and awards received.

CPS' primary purpose for releasing Directory Information is to highlight student accomplishments. Sometimes, the district and/or school takes photos and captures video/audio that may be placed on the district's websites, social media channels, approved publications and/or may appear within a broadcast media news story.

If you agree that CPS may release your child's Directory Information, photos, video/audio**, *you do not need to return this form*** and no further action is needed. If you do not want CPS to release directory information, photos, video/audio or to military recruiters, please check the applicable boxes below.

Directory and General Public Release

Parents, legal guardians, or students aged 18 and older may refuse to allow CPS to release Directory Information by checking the box returning this form to the school by the end of September.	☐ CPS **may not** release Directory Information about my child.

Media Release

Parents, legal guardians, or students aged 18 and older may refuse to allow CPS to release photos and video/audio that features students on the district's websites, social media channels, and publications or may appear on broadcast news. Opting-out does not cover events or performances that are open to the public.	☐ CPS **may not** release photos and/or video/audio of my child.

Military Recruiters:

Per federal law, CPS must release the names, addresses and telephone numbers of high school students to military recruiters, unless the parent, legal guardian, or student aged 18 and over specifically objects.	☐ CPS **may not** release my child's name, address and phone number to military recruiters.

Student Information

Last Name: _____ First Name: _____

Birth Date: ___/___/___ School: _____ Grade: _____ Home Room: _____

Please check one:

☐ I am the student, and I am 18 years of age or older.

☐ I am the parent or legal guardian of the student and the student is under 18 years of age.

Parent/Guardian Name (Please Print): _____

Signature: _____ **Date**: ___/___/___

Parents/guardians and/or eligible students who believe their rights under the Federal Education Rights and Privacy Act (FERPA) have been violated may file a complaint with: Family Policy Compliance Office, U.S. Department of Education, 400 Maryland Avenue, SW, Washington, D.C., 20202-4605. www.ed.gov/offices/OM/fpco. Informal inquiries may be sent to the Family Policy Compliance Office via email: FERPA@ed.gov.

Community Learning Center
Cincinnati Public Schools
2651 Burnet Avenue
Cincinnati, Ohio 45219
Phone: (513) 363-0154

2025-26 Parent / Guardian Consent Form
Student Computerized Records

The Cincinnati Public Schools partners with a number of organizations to assist with addressing student needs.

The partners offer an array of services related to the following areas: tutoring, mentoring, health, and after school services. Services may be organized through Resource Coordinators who are assigned to individual schools.

The Resource Coordinators or partner organizations may request access to the student computerized records system, including IEP data, to view personally identifiable student data. This data may also be shared with staff and volunteers working with the partner organization. This would enable the Resource Coordinators and partner organizations to identify and assign appropriate services to students. If granted access, the Resource Coordinator or partner organizations must maintain the confidentiality of student information, and not re-disclose the information to persons not identified in this consent. The Resource Coordinator and partner organizations are only permitted to access student records in their own program and to the extent necessary to perform his/her duties. In addition, the Resource Coordinator or partner organizations may share information about his/her program with school district staff and other partners listed below, in order to better serve students.

Confidential information may only be shared to the extent that the information is relevant to the student's educational progress, safety, or well-being. Student information may be disclosed in a grave medical emergency which necessitates facilitation of medical care.

A parent/guardian authorization is required to allow the coordinator and partner organizations access to your child's data. Please select the partners below that you give consent to.

Resource Coordinator and/or school will enter partner options below

● _____	● _____
● _____	● _____
● _____	● _____

I have read the above and consent to all partners listed above serving <u>Cincinnati Public Schools</u> to release, obtain, and exchange my child's information from school district staff and partners listed above.

_____ **Print Parent/Guardian Name**

_____ **Print Student Name (one student per form)**

_____ **Parent/Guardian Signature**

_____ **Date**

_____ **School Name**

_____ **Grade**

_____ **Phone Number**

For Office Use Only
Student ID #: _____

Student Acceptable Use Policy and Internet/Network Safety Agreement

Cincinnati Public Schools 2025-2026 School Year

Grades PreK - 3

Student Agreement

Student Acceptable Use Policy and Internet/Network Safety Agreement

Cincinnati Public Schools 2025-2026 School Year

Grades PreK - 3

1. **What is an AUP**?

   Acceptable Usage Policy. An agreement or promise that you will follow the rules when using school computers, iPads, and other devices.

2. **Why is the AUP important?**

   Our school wants to keep you and the equipment you use safe. The AUP tells you the rules and your job when using computers, iPads, and devices.

   The AUP reminds us that when you are using computers, iPads, and other devices it is not private. Your teacher is watching and so are others on the internet. You must remember to be respectful, responsible, and safe.

3. **What is the MDA?**

   The Mobile Device Agreement. An agreement or promise that you will take care of the school computers, iPads, and other devices.

4. **Why is the MDA important?**

   The Mobile Device Agreement helps remind you to keep the computers, iPads, and devices in good working condition. It also tells you there are consequences if you destroy or damage the computer, iPad, or device.

Student Acceptable Use Policy and Internet/Network Safety Agreement

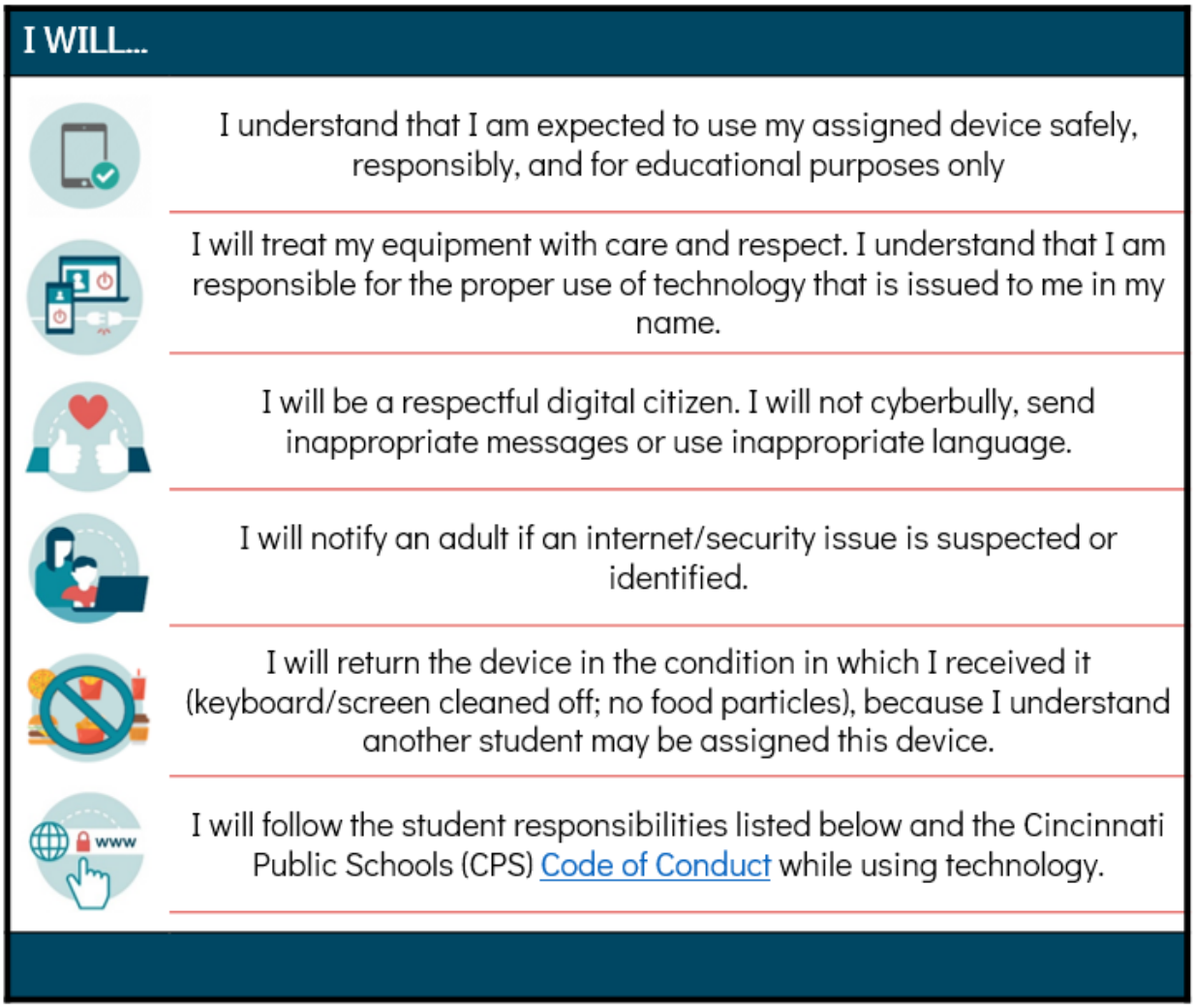
Cincinnati Public Schools 2025-2026 School Year

Grades PreK - 3

For all questions, please call the Family Technology Support Center: 513-363-0688

Student Acceptable Use Policy and Internet/Network Safety Agreement
Cincinnati Public Schools 2025-2026 School Year
Grades 4-12

Student Agreement



CPS "Code of Conduct" can be found at: https://www.cps-k12.org/our-students/policies-and-guidelines/code-of-conduct

Student Responsibilities

1. **I will be responsible for my assigned device and accounts.** I will not share my account information, passwords, or other information used to access programs to anyone. I also know that I should not access accounts under someone else's name. If I see someone else's information, when using a shared device, I

will tell an adult and wait to use the device until an adult has removed the material.

2. **I will be kind and respectful in my language and how I treat others while online.** I will not intentionally be hurtful, bully, harass, intimidate, stalk, or threaten other students and staff ("cyberbullying"). I will only use language on the internet and in my school email that I would use in the classroom with my teacher. I will tell a teacher if I see anything hurtful to another student online.

3. **I will use the CPS Network responsibly.** I will not access, post, display, or otherwise use material that is not school appropriate. I will not look up web pages, apps, or documents that have content that is inappropriate. I will not create or share photos, videos, or texts/chats that are inappropriate. Inappropriate content can include things that are discriminatory, mean-spirited, improper, sexually explicit, violent, or disruptive language. I will not download any files, including music and video files, unless a teacher gives me permission.

4. **I will be honest about who I am online.** I will not pretend to be anyone else online. I will not send email, create an account, or post any words, pictures, or sounds using someone else's name. I will not use another person's login name or password. I will not "plagiarize." When I use information from a website, I need to let people know where I got the information and cite my sources. I will obey copyright laws and will not download words, pictures, video, or music that belongs to someone else.

5. **I will protect the security of the CPS Network.**. I will not try to change security settings or install any software on school devices without permission. I will not use a phone, personal laptop, or any electronic device in school without a teacher's permission. I will not "hack" into any systems to manipulate data of the district of other users.

6. **I will protect all CPS property that is assigned to me.** I will not break or destroy any equipment on purpose. I will not move any equipment, including keyboards and mice, without permission. I will not disrupt or harm district technology (such as destroying district equipment, placing a virus on district computers, adding or removing a computer program without permission, changing settings on shared computers, etc).

7. **I will protect myself and others while online**. I will not publish any material on a school website, wiki, blog, podcast, or discussion group without permission. I will not publish a picture, including my picture, with the person's first or last name attached. I will not give personal information (such as name, address, telephone number, Social Security number, or other personal information) of mine, another student, staff member, or anyone else without permission or with the intent to threaten, intimidate, harass, or ridicule that person.

Frequently Asked Questions

What is an AUP?

AUP stands for "Acceptable Use Policy." It means that you agree to only do "acceptable" things when you are using Cincinnati Public Schools (CPS) internet and technology. For details on what is "acceptable" see the above agreements and responsibilities as well as your building and/or classroom rules. The AUP is an agreement that you must digitally sign for you to be allowed to use CPS network and equipment.

What is an MDA?

MDA stands for "Mobile Device Agreement." It means that you agree to handle devices and equipment in a safe and secure manner. Please note that within this agreement it states you may be charged for repair or replacement costs to your device if there is damage caused by:

A. horseplay in the vicinity of the device.
B. spilling liquid or food on the device.
C. closing the monitor on an object (e.g. pen, pencil, calculator, paper clip, etc.).
D. the device not being cleaned off when turned in.
E. theft of the device resulting from not securing the device properly.
F. loss of missing devices.

Why does CPS have an AUP/MDA?

A lot of people use the Cincinnati Public Schools' network and school devices. We need to make sure that our devices and printers are in working order and that everyone is safe and comfortable when using the network.

Why do I have to be responsible for what I do on the CPS District Network?

It is important that we are all responsible digital citizens in order for all staff and students to have safe spaces to learn and grow. Using the internet and district technology is a privilege given to help in achieving that goal. Please understand that the CPS network, web pages, and email accounts are NOT private. CPS staff, as well as the Cincinnati Police, are able to "monitor" all activity on school devices. (Including everything you read, what you write, and the web pages that you visit on school devices). This is done to ensure that district technology is being used for safe and appropriate activities. Pause and think before you use your device to ensure you don't do anything online that you would not want your teachers or parents to see.

What happens if a student does not follow the rules in the AUP/MDA?

The CPS AUP/MDA are in place to ensure we all have safe spaces to learn and grow while using technology. If you see anything online that does not follow the agreements and responsibilities, report it to a teacher or adult IMMEDIATELY! Students who do not follow the CPS AUP/MDA will receive consequences up to the loss of device privileges. Consequences will be determined by your building principal according to your school's rules and procedures. Please note the Cincinnati Police Department will be contacted if your actions have broken a law. Lastly, you could be responsible for fees associated with your device(s).

Education Center - Office of Environmental Health and Safety
2651 Burnet Avenue Cincinnati OH 45219-5381 Phone: 513-363-0107 Fax 513-363-0373

DATE: 6/25/2025

TO: Parents, Staff, School Organizations and Employee Representative Groups

RE: AHERA Annual Notification

This memo is to notify all parents, staff, school organizations and employee representative groups that the Cincinnati Public School District complies with the United States Environmental Protection Agency's (U.S. EPA) Asbestos Hazard Emergency Response Act (AHERA) regulations.

These regulations require every private, parochial and public school district to inspect all school buildings for asbestos containing material, assess the condition of the asbestos material and draw up a plan on how the district is to manage the asbestos containing material.

The Cincinnati Public School District has had all buildings inspected for asbestos and has compiled the results in the Asbestos Hazard Emergency Response Ace (AHERA) – *Asbestos Management Plan*. The plan for each school is located in the main school office and is available for review.

The Asbestos Management Plan should be checked when planning all building renovations so as to prevent the disturbance of asbestos. All planned repairs and renovations of school district buildings, which involve the disturbance of known asbestos containing material, are completed by certified persons who are trained to work with asbestos material. These projects are completed in a safe manner by following procedures detailed in the Asbestos Management Plan.

The school district continues to monitor the condition of all asbestos containing building material by having district employees check the condition every six months. In addition, the district has trained inspectors from outside the district conduct a major re-inspection of all buildings every three years. The results of these required inspections are available in the Asbestos Management Plan.

If your school has had asbestos abatement projects, you will find a brief description of the projects in the Asbestos Management Plan.

Any questions or concerns about the implementation of the AHERA regulations should be given to the building administrator who will contact the Environmental Health and Safety Manager, if necessary, to obtain clarification.

Sincerely,

Steven Knapik

Environmental Health and Safety Manager

Sign Up Today

Smart911.com™

- Educate your children **on when and how** to dial 9-1-1 in an emergency, and make sure your children know their home address.

- Create a Smart911 Safety Profile at **www.smart911.com** to provide 9-1-1 staff and First Responders — police officers, firefighters and Emergency Medical Services — with information that can help protect your family in an emergency.

Signing up for Smart911 gives First Responders important information you have provided that can help **locate you and help you** in an emergency.

Other safety reminders:

- To avoid injury, choose your child's backpack carefully, making sure it won't get too heavy. A loaded backpack should weigh no more than 10 percent to 20 percent of your child's body weight.

- Don't put your child's name on a backpack, or on any outer clothing.
If your child's name is easily readable, it makes it easier for strangers to approach and begin a conversation.

- Teach your children that **any adult they don't know is a stranger**, even if the person looks nice, and that they should never go anywhere with a stranger.

School Year 2025-2026

Dear Parent or Guardian,

Welcome back! We're thrilled for another exciting school year and can't wait to see all our students achieve great things.

Please complete and return the required health forms. You can pick these up at the school or find them online at: https://www.cps-k12.org/our-students/forms.

Here's a quick rundown of the important forms:

- **Emergency Medical Authorization**: This form allows us to get emergency treatment for your child if they become ill or injured at school and we can't reach you.
- **Health History Update**: Ohio law requires this form every school year. It provides us with important health information about your child.
- **Additional Forms for Chronic Conditions**: If your child has a chronic condition like asthma, diabetes, or a seizure disorder, please get additional forms from your school's health office.

Medication Forms (*Only complete these if your child needs medication during school hours*):

- CPS Administration of Prescription Medication
- CPS Administration of Over-the-Counter Medication

Please note: Both medication forms require signatures from both the healthcare provider and the parent/guardian.

If you would like your child to receive services from any of our **School Based Health Centers**, please fill out the appropriate consent form:

- Cincinnati Children's Hospital Medical Center *(Hughes, Rockdale, South Avondale)*
- Cincinnati Health Department *(AWL, Aiken, Ethel Taylor, JP Parker, Mt. Airy, Oyler, Riverview East, Roberts, Roll Hill, Shroder HS, Taft HS, West High/Dater HS, Withrow)*
- Crossroads *(Rothenberg, Taft Elementary)*
- Mercy *(Sayler Park)*
- WinMed *(Bond Hill, Winton Hills, Woodward)*

Thank you for taking care of these important documents and for helping us keep your child healthy!

Angie Maddox
School Health Manager

Health History Update - 2025-2026

Please fill out and return to the school health office. Thank you.

Ohio law requires that a current Health History form be on file for every student.

_____ _____ _____/_____

Student's Name Date of Birth Grade/Homeroom

_____ _____ _____

Doctor's Name Phone Number Last checkup or visit

_____ _____ _____

Dentist's Name Phone Number Last checkup or visit

Insurance: ____Medicaid (Circle one: CareSource/ Molina/ United Health Care/ Paramount/ Buckeye)

____Private Insurance Provider's Name_____

____None

Any history of the following problems? (Circle Y for YES or N for NO)

History For Student and then Family	Student	Family
Allergies: Seasonal/Hay fever	Y N	Y N
Life Threatening Allergy to:_____ EpiPen prescribed	Y N Y N	
ADD/ADHD	Y N	Y N
Anemia or Other Blood Problems	Y N	Y N
Asthma	Y N	Y N
Behavioral Problems _____	Y N	Y N
Blood Pressure Problems (High/Low)	Y N	Y N
Developmental Problems _____	Y N	
Cancer – type _____	Y N	Y N
Chronic Diarrhea or Constipation	Y N	Y N
Chronic Ear Infections	Y N	
Depression	Y N	Y N
Diabetes	Y N	Y N
Drugs or Alcohol Used During Pregnancy	Y N	
Eczema/Chronic Skin Condition	Y N	Y N

History For Student and then Family	Student	Family
Emotional/Psychological Problems	Y N	Y N
Frequent Headaches Head Injury/Concussion? When _____	Y N Y N	Y N
Frequent Stomachaches	Y N	Y N
Hearing Problems	Y N	Y N
Heart Disease – type _____	Y N	Y N
Kidney Disease – type _____	Y N	Y N
Learning Problems _____	Y N	Y N
Prematurity or Birth Weight under 5 lb.	Y N	
Seizure Disorder/Epilepsy/Tics	Y N	Y N
Sickle Cell Disease	Y N	Y N
Sleep Problems	Y N	Y N
Speech Problems	Y N	Y N
Toothaches/Dental Problems	Y N	Y N
Problems with Vision Wears Glasses	Y N Y N	Y N
Surgery? What type?_____	Y N	

Tuberculosis (TB) Risk Assessment:

Is your child in contact with any of the following people: Immigrants from another country, someone diagnosed with or treated for TB, incarcerated children or adults, HIV infected, homeless, nursing home residents, institutionalized children or adults, illegal drug users, migrant farm workers?

F or your child, please circle Yes or No below, and explain any Yes answers.
Diagnosed or treated for TB? ___No ___Yes _____
Immigration from another country? ___No ___Yes _____
Traveled to another country? ___No ___Yes _____
Ever been in jail or in 2020 (Juvenile Detention Center)? ___No ___Yes

Student's Name_____

Has your child received the COVID-19 Vaccine? ___No ___Yes Dates: _____

Please list any **CURRENT** health problems or conditions your child has (may be same as above): _____
_____

Please list any allergies (include **food, medications**, **environmental, seasonal, etc.**):
_____

Please list any dietary restrictions (medical or non-medical) _____

Does your child see a specialist? Yes____ No____If yes, please list condition, doctor's name, and phone number:

_____

Please list any medications (prescribed or over-the-counter) your child takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches): _____

_____

SPECIAL NOTE: If your child must take any medications at school, including emergency medications (such as an inhaler or Epi Pen), you must fill out a CPS Administration of Medication form (available at the school).
Has your student had any operations, serious injuries or overnight hospital stays? No___Yes ____; please explain:

_____

Has your child ever been pregnant? No ___Yes ____; please explain:
_____

Has your child ever been a victim of abuse? No ___Yes ____; please explain:

_____

Has anything bad, scary or sad happened to your family? No ___Yes ____; please explain:

_____

School Concerns

Is your child in a special education class? No ___Yes ____; please explain: _____

Has your child repeated a grade? No ___Yes ____; details: _____

Does your child get into trouble at school? No ___Yes ____; details: _____

What are your child's grades on the report card? _____

Any changes recently in grades? No ___Yes ___

Name of Parent/Guardian _____ Date _____

How can we reach you during school hours? Cell:_____ Work_____ Other_____

Emergency Medical Authorization Form

Fill out this form and return it to your child's school.

Student's Name: _____ ID #: _____ Homeroom: _____ Birth Date: _____

School: _____ Grade: _____ Year: _____

Student's Address: _____ Apt.: _____ Phone: _____

City: _____ State: _____ Zip: _____

Purpose — To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Parent / Guardian Name: _____ Daytime Phone: _____

Parent / Guardian Name: _____ Daytime Phone: _____

Other's Name: _____ Daytime Phone: _____

Name of Relative or Child-care Provider: _____

Relationship: _____ Daytime Phone: _____

Address: _____ Zip: _____

PART I or PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT I hereby give consent for the following medical-care providers and local hospital to be called:

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Emergency Room Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address: _____ Zip: _____

PART II: REFUSAL TO GRANT 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 to take the following action:

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address: _____ Zip: _____

Cincinnati Health Department

School-Based Health Center Enrollment Packet

PLEASE COMPLETE AND SIGN ALL PAGES.

STUDENT/PATIENT'S NAME: _____ **DOB:** ___/___/____ **Gender: M/F Trans: MTF/FTM or Non-Binary**

Child's Social Security #: _____-_____-_____ Medical Card/Insurance ID: _____

☐ CareSource ☐ Molina ☐ Buckeye ☐ Paramount ☐ United Health Care ☐ No Insurance ☐ OTHER _____

MEDICAL HEALTH CARE SERVICES:

☐ **YES,** I consent for my child to receive **MEDICAL CARE** including routine well childcare* (e.g. work, daycare, and sports physicals) appropriate immunizations, fluoride varnish and treatment for illness or injury including over the counter medications unless emergency services are needed. (*Note: well child care includes vision/hearing screening, urine and blood tests, immunizations as needed, and an external genital exam when appropriate). My child may be **TRANSPORTED/ACCOMPANIED** to and from medical services by a school designee. I, the parent or guardian of above-named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and the Cincinnati Public School District (CPS), its board personal injury or damage resulting from the transportation of my student to and from health services. ***Please note: in Ohio, minors may access confidential service for sexually transmitted infections and family planning, including provision of contraception such as condoms or birth control pills without parental consent.***

☐ **NO,** I do not wish for my child to receive **MEDICAL CARE** at the school-based health center (SBHC)

DENTAL HEALTH CARE SERVICES:

☐ **YES,** I consent for my child to receive **DENTAL SERVICES** at a Cincinnati Health Department (CHD) Center or school-based/mobile clinic including preventive care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals if necessary. Sealants and other preventive procedures will be provided at school. My child may be **TRANSPORTED/ACCOMPANIED** to and from dental services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

☐ **NO,** I do not wish for my child to receive **DENTAL SERVICES**

EYE CENTER SERVICES:

☐ **YES,** I consent for my child to receive **EYE CENTER SERVICES** at the OneSight Vision Center at Oyler School or Academy of World Languages, which may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction. My child may be **TRANSPORTED/ACCOMPANIED** to and from eye center services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

☐ **NO**, I do not wish for my child to receive **VISION SERVICES**

⇨ _____ _____ _____

Parent / Guardian Signature (or patient if 18 or older) **Parent/Guardian Name** (PRINT) **DATE**

Phone (best) _____ Phone #2_____ Phone #3_____

_____ _____ _____

ADDRESS STREET APT CITY STATE ZIP

I give consent for my child to obtain the services that I have marked in the boxes above. I agree to the terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in Program Description form (attached). **Consent in effect until terminated in writing** by Parent/Guardian.

STUDENT/PATIENT'S NAME: _____ DOB: ___/____/____

To provide health services for your child we need the following information:

Parent/Guardian Name: _____ Parent/Guardian's Date of Birth: _____

Relationship to Child: _____ Parent/Guardian's Social Security No.: _____

Address: _____ City/State/ZIP: _____

Emergency Contact Person: _____ Phone Number: _____

Your Child's Health History

❖ Do you have a **Primary Care Doctor**? ☐ YES ☐ NO

Doctor Name/Clinic: _____ Phone #: _____ Fax #:_____

Date of last complete yearly physical examination (head to toe): _____

❖ Do you have a **Primary Dentist?** ☐ YES ☐ NO

Dentist Name/Clinic: _____ Phone #: _____ Fax #:_____

Date of last routine dental check-up: _____

❖ Do you have a **Primary Eye Doctor?** ☐ YES ☐ NO

Eye Doctor Name: _____ Phone #: _____ Fax #:_____

Date of last routine vision exam: _____

❖ Do you have a **Preferred Pharmacy?** ☐ YES ☐ NO

Preferred **Pharmacy**: _____ Phone #: _____ Fax #:_____

Please list any **CURRENT** health problems or conditions your child has:

Please list any **allergies** (include **food, medications**, environmental, seasonal, etc.):

Does your child see a specialist? If yes, please list condition, doctor's name, and phone number:

Please list any medications (prescribed or over-the-counter) your child takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches):

****<u>SPECIAL NOTE</u>: If your student needs to take any medications at school, including emergency medications (like an inhaler or Epi Pen), you <u>must</u> complete a CPS Administration of Medication form****

Has your child had any operations, serious injuries, or hospitalizations? ☐ No ☐ Yes

Please provide reason and dates: _____

Has your child ever been pregnant? ☐ No ☐ Yes If *Yes*, how many living children has your child given birth to: _____

Has your child been a victim of abuse? ☐ No ☐ Yes

Has anything bad, scary or sad happened to your family? ☐ No ☐ Yes

Please explain: _____

School Concerns: Explain any YES answers on the line provided.

Is your child in a special class (Special Ed / IEP / 504 Plan)? ☐ YES ☐ NO _____

Has your child repeated a grade? ☐ YES ☐ NO _____

Does your child get into trouble often at school? ☐ YES ☐ NO _____

What are your child's grades? _____ ***Is this a change?*** ☐YES ☐ NO

(Please continue to the next page)

Cincinnati Public Schools

Health History Update:

Please complete and return to the school nurse or office. Thank you.
Ohio State Law requires that a Health History form be on file for every student.

_____ _____ _____/_____
Student's Name Date of Birth Grade/Homeroom

_____ _____ _____
Doctor's Name Phone Number Last checkup or visit

_____ _____ _____
Dentist's Name Phone Number Last checkup or visit

Insurance: ____Medicaid (circle: CareSource/ Molina/ United Health Care/ Paramount/ Buckeye)

____Private Insurance Provider Name_____

____None

Any history of the following problems? (Please circle **Y** for Yes or **N** for No)

History For Student and then Family	Student	Family
Allergies: Seasonal/Hay fever	Y N	Y N
Life Threatening Allergy to: _____ EpiPen prescribed	Y N Y N	
ADD/ADHD	Y N	Y N
Anemia or Other Blood Problems	Y N	Y N
Asthma	Y N	Y N
Behavioral Problems _____	Y N	Y N
Blood Pressure Problems (High/Low)	Y N	Y N
Developmental Problems _____	Y N	
Cancer – type _____	Y N	Y N
Chronic Diarrhea or Constipation	Y N	Y N
Chronic Ear Infections	Y N	
Depression	Y N	Y N
Diabetes	Y N	Y N
Drugs or Alcohol Used During Pregnancy	Y N	
Eczema/Chronic Skin Condition	Y N	Y N

History For Student and then Family	Student	Family
Emotional/Psychological Problems	Y N	Y N
Frequent Headaches Head Injury/ Concussion	Y N Y N	Y N
Frequent Stomachaches	Y N	Y N
Hearing Problems	Y N	Y N
Heart Disease – type _____	Y N	Y N
Kidney Disease – type _____	Y N	Y N
Learning problems _____	Y N	Y N
Prematurity or Birth Weight under 5 lb.	Y N	
Seizure Disorder/Epilepsy/Tics	Y N	Y N
Sickle Cell Disease	Y N	Y N
Sleep Problems	Y N	Y N
Speech Problems	Y N	Y N
Toothaches/Dental Problems	Y N	Y N
Problems with Vision Wears Glasses	Y N Y N	Y N
Surgery what type:_____	Y N	

Tuberculosis (TB) Risk Assessment:

Is your student in contact with any of the following persons: Immigrants from another country, someone diagnosed with or treated for TB, incarcerated children or adults, HIV infected, homeless, nursing home residents, institutionalized children or adults, illegal drug users, migrant farm workers?

For your student/student, please circle yes or no below, and explain any yes answers in space provided.

Diagnosed or treated for TB? ___ No ___Yes _____
Immigration from another country? ___ No ___ Yes _____
Traveled to another country? ___ No ___Yes _____
Ever been in jail or in 20/20 juvenile center? ___ No ___ Yes_____

Has your child received the COVID-19? Yes No

Consent for Nitrous Oxide Sedation

Patient Name:_____

If your child needs dental treatment, it may be beneficial or necessary to use nitrous oxide sedation in order to complete the dental treatment. Nitrous oxide relaxes children, makes them more comfortable, and gives them an all-around better experience at their dental appointment. By signing this form ahead of time it will be easier for us to do the treatment in a more timely and efficient manner. We will attempt to call you prior to using nitrous oxide on your child. Please read the following and sign at the bottom if you consent to treatment with nitrous oxide sedation. It will only be used if necessary.

I give permission for a Cincinnati Health Department dentist to give my child nitrous oxide sedation if indicated. I understand that some side effects could occur including:

1. Nausea and vomiting – we suggest that no food be eaten for at least two hours before the appointment.
2. Excessive sweating and patient may get red or flushed.
3. An unusually high amount of saliva is sometimes produced.
4. Although not common, a patient may get a sensation of having the chills.
5. In unusual circumstances, a child may become temporarily hyperactive.

The benefits include relaxation and possibly eliminating the need for local anesthetic injections (“Novocaine”). For those patients who may need both, the use of nitrous oxide/oxygen will make the injections much easier for the patient.

At no time will the patient be “asleep” and at all times the patient will be given more oxygen than what is present in room air. Patients will be monitored continually by the dentist and staff, and a parent can be present as well if requested.

If you would like to be present, please make a note on the top of this form and we will be happy to schedule an appointment for you at your convenience.

☐ I consent for my child to receive nitrous oxide sedation as deemed necessary by the dentist. I understand the dental staff will attempt to contact me prior to administering nitrous oxide.

☐ I do not consent for my child to receive nitrous oxide sedation.

⇨ _____

Signature (Parent/Guardian) Phone Number Date

PLEASE REVIEW THE FOLLOWING INFORMATION

Program Description

School-Based Health Center

Cincinnati Health Department

Welcome to the School-Based Health Center. The School-Based Health Center makes medical, dental and vision care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center. If your child/adolescent develops a dental problem at school, a dentist can see your child at one of school-based dental centers located at Academy of World Languages, Withrow High School, Western Hills High School, Oyler School, Crest Smiles Shoppe, or other CHD Health Centers. If you have any questions or need help with the application, please call the School Health Program 357-2809 or contact your school nurse

Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex; or sexual orientation.
- To have a health care assessment and plan of care and participate in your health care plan.
- To talk to your health care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow 30 days for completion of insurance or disability forms..
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency call 911 or go to the nearest emergency room. If you have an urgent issue and would like to speak with the provider on call, please call 357-7320.

Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Cincinnati Health Department sliding fee scale. This information will be kept strictly confidential.
- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid, you can stop by our center or call 513-357-2787.

Regarding the SHARING OF HEALTH INFORMATION:

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's regular doctor/clinic.
- The PHHC, School-Based Health Center and/or the Cincinnati Health Department (CHD) school nurse will share medical information with each other as needed.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or a community site. The mental health provider will contact you for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.
- Dates of service regarding completed dental, vision and medical care (ie. Immunizations, annual well-child check and asthma care) may be shared with your child's school if you agree and sign the Authorization form provided with this consent.

I have the right to receive or review a copy of the Notice of Privacy Practices. I acknowledge that I have been offered a copy of the Notice of Privacy Practices:

⇨ I have received or reviewed a copy (signature and date) _____

I do not want a copy (signature and date) _____

I authorize the SBHC to call my home or cell phone number and leave a message with an adult that answers the telephone or on the voicemail pertaining to my child's medical care, including laboratory results.

INFORMED CONSENT FOR SILVER DIAMINE FLUORIDE

Silver diamine fluoride (SDF) is an antimicrobial liquid used to treat tooth sensitivity and to help stop tooth decay. Reapplication of SDF may be necessary to better control caries progression and is recommended every 3, 6 or 12 months but may be applied more frequently if needed. Treatment with SDF may not eliminate the need for dental fillings or crowns to repair function or esthetics. Additional procedures may incur a separate fee.

Facts for consideration:

- The procedure involves: 1) Proper isolation of the area and drying of affected teeth. 2) Rub a small amount of SDF on the decayed area. 3) Allow SDF to act on the tooth surface for at least 1 min, preferably up to 4 minutes. 4) Rinse tongue and oral mucosa.
- I should not be treated with SDF if: 1) I am allergic to silver or ammonia. 2) There are painful sores or raw areas on my gums or anywhere in my mouth (i.e., ulcerative gingivitis, gingivostomatitis).

Benefits of SDF treatment:

- It is quick, easy and painless.
- No need to numb teeth.
- It arrests 80% of cavities when applied twice yearly.
- It can help relieve tooth sensitivity.
- It is a temporary treatment option for young, fearful, or special needs patients that may require sedation for extensive dental care.

Risks related to SDF:

- **The affected area will stain black permanently.** Healthy tooth structure will not discolor. Stained tooth structure can be covered with a filling or a crown in the future.
- If accidently applied to the skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off, and it will disappear in a few days to 2 weeks.
- You may notice a very temporary metallic aftertaste.
- SDF may not work for all cavities and decay will progress with poor oral hygiene and food impaction. In that case, the affected tooth will require further treatment, which can involve a filling or a crown, root canal therapy, extraction, or referral for specialty dental care.

Alternatives to SDF, not limited to the following:

- No treatment, which may lead to progression of cavities, severe pain and more serious dental infection.
- Depending on the location and extend of the tooth decay as well as the level of patient behavior and cooperation, other treatment may include fluoride varnish, a filling or crown, extraction, or referral to a specialist.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner. I have seen the photo displaying the discoloration of the cavity after SDF application. I consent to have Silver Diamine Fluoride (SDF) treatment with a dentist or another qualified dental staff at any dental site operated by the Cincinnati Health Department.

Patient Name: _____ Date of Birth:_____

Patient/Guardian Signature:_____ Date:_____

CHD Dental Staff Signature: _____ Date:_____

Authorization for Administration of Over-the Counter Medications at School

This form expires at the end of the current school year (2025-2026).

Student's Name _____ Date of Birth _____ School Year _____

Street Address _____ Apt. No. _____ City _____ State _____ Zip _____

School _____ Grade _____ Homeroom _____

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after-school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

(Circle yes or no for each medication listed below. *Physician to complete dosage and time/frequency)

Over-the-Counter Medication (Parent to Complete)	**Circle**		**Dosage (Physician to complete)**	**Time/Frequency (Physician to complete)**
Acetaminophen (Tylenol) for headache, toothache or minor pain	Yes	No		
Ibuprofen for headache, toothache, minor pain or menstrual cramps	Yes	No		
Anti-itch cream or lotion	Yes	No		
Cough drops	Yes	No		
Tums (antacid)	Yes	No		

Is student allergic to any medications? ☐ No ☐ Yes, allergic to _____

Severe reactions that should be reported to the physician: _____

Student's Provider (Physician / Nurse Practitioner / Dentist) *Complete dosage and frequency above.

Provider's Signature:_____Date: _____

Provider's Name:_____ Emergency Phone _____

I give permission to the Cincinnati Public Schools' designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Cincinnati Public Schools and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

_____ _____

Signature of Parent or Guardian Date

_____

Please Print Name of Parent or Guardian

How can we reach you during school hours?

Work Phone _____ Cell Phone _____ Home Phone _____ Other _____

Authorization or Administration of Prescription Medication Form

This form expires at the end of the current school year (2025-2026).

Parent/Provider Request for School Personnel to Give Prescription Medicine

School:_____Grade:_____Homeroom:_____School Fax: _____

Cincinnati Board of Education policy, Section 5330, requires consent of the parent, guardian, or eligible student 18 years or older before medication (including prescription medication, inhalers, Epinephrine, etc.) can be given to a student by school personnel. The following information is necessary to comply with this policy. **Please answer all questions and return this completed form to your student's principal or school health office.**

Student's Name:_____Date of Birth:_____Home Phone: _____

Street Address:_____Apt. #:_____City:_____State:_____Zip: _____

TO BE COMPLETED BY THE STUDENT'S PROVIDER (Physician / Nurse Practitioner / Dentist)

Name of Medication:_____Dosage:_____

Time/Frequency:_____How Administered:_____Date to Begin: _____

Permission for this medication is only valid through the end of the current school year unless otherwise noted. EXCEPTION: For emergency medications for asthma, anaphylaxis, seizures or diabetes, this permission can be valid for 3 years. A provider order is required for any changes in this medication.

Date to Terminate Emergency Medication: _____ (3 years)

Please attach an emergency action plan with procedures to be followed if emergency medication does not alleviate student's emergency.

For Epinephrine orders only: I have determined that this student is capable of possessing and using this auto injector/epipen appropriately and have provided the student with training in the proper use of the auto-injector.

Severe reactions that should be reported to the physician: _____

Special conditions for storage of drug: _____

Provider's Signature:_____**Date:**_____

Provider's Name:_____**Emergency Phone #:** _____

TO BE COMPLETED BY THE STUDENT'S PARENT OR ELIGIBLE STUDENT

The medicine must be in pill, capsule, liquid, auto-injector or inhaler form, and must be clearly marked from the pharmacist. The label must show the student's name, medication name, dosage directions, doctor, and prescription number.

Pharmacy:_____Phone Number: _____

As the parent/guardian of this student (or eligible student), I give permission for the principal or designee to administer the prescribed medication. The undersigned agrees not to file or make any claim for negligence in connection with the administration or non-administration of this medicine(s) and further agrees to hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines. I will inform the school if there is a change in any of this information.

Please check the following if applicable:

For Students with Asthma:

_____ As the parent/guardian of this student, or myself, an eligible student, I authorize the student (or myself) to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school participates.

For Students with EpiPen/Twinject/Auto Injector:

_____ As the parent/guardian of this student, or myself, an eligible student, I authorize the student to possess and use an Epinephrine Auto-Injector, as prescribed, at the school and any activity, event, or program in which the student's school participates. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered**. I will provide a backup dose of the medication to the school as required bylaw.**

Name of Parent / Guardian / Eligible Student (please print):

_____

Signature of Parent / Guardian / Eligible Student:_____**Date:**_____

Primary Emergency Phone: _____**Secondary Emergency Phone:** _____

Cincinnati Health Department
School and Adolescent Health Program
Consent Form for 2025-2026 Seasonal Influenza Vaccine

COMPLETE THIS FORM ONLY IF YOU WANT YOUR CHILD TO GET THE FLU VACCINE

A. SCHOOL NAME: _____

STUDENT NAME (Last)	**(First)**			**(M.I.)**	**GRADE/HR**
DATE OF BIRTH	**AGE**	**GENDER** **M / F**	**RACE**	**PHONE NUMBER**	
STREET ADDRESS	**CITY**		**STATE**	**ZIP**	

INSURANCE STATUS:
☐ **Medicaid** ☐ **CareSource** ☐ **United Healthcare Community Plan** ☐ **Molina** ☐ **Paramount** ☐ **Buckeye**
☐ **No Insurance** ☐ **Private Insurance** _____ **Insurance Billing#**_____
Medical Card Billing Number# _____ **Child's SS#**_____
*No student will be denied the flu vaccine due to inability to pay or lack of insurance

B. In order to determine if your child needs a booster dose, please answer this question**:**

1. Did your child receive **2 doses** of seasonal flu vaccine since July 2010? ☐ Yes ☐ No ☐ Unsure

C. Please answer all of the following questions:

	YES	**NO**
1. Is the student sick today with fever or respiratory illness?	☐	☐
2. Does the student have a serious allergy to eggs, thimerosal or another component of the flu vaccine?	☐	☐
3. Has the student ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has the student ever had Guillain-Barré Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving flu vaccine?	☐	☐

D. Please answer all of the following questions:

	YES	**NO**
1. Does the student have a long term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder?	☐	☐
2. If the student is between the ages of 2 and 4 years old, in the past 12 months has a health care provider told you that he or she had wheezing or asthma?	☐	☐
3. Does this student have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as high dose steroids, or cancer treatment with radiation or drugs?	☐	☐
4. Does the person have close contact with someone who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	☐	☐
5. Is the person on long-term aspirin or aspirin-containing therapy (for example, does the person take aspirin every day)?	☐	☐
6. Is the student receiving anti-viral medications?	☐	☐
7. Is the person pregnant or could become pregnant in the next month?	☐	☐
8. Has the person received any of the following vaccinations within the past 30 days? MMR, Varicella, or Flu Mist? If yes, give type and date. Recent Vaccinations: _____ Date received: _____	☐	☐

E. Consent

CONSENT FOR VACCINATION:
I understand I will receive the **Flu Vaccine Information Statement** and be offered the **Cincinnati Health Department Notice of Privacy Practices prior to my child receiving the vaccine.**

I GIVE CONSENT for the student named at the top of this form to receive the Flu vaccine.

Signature of Person/Parent/Legal Guardian _____ Date: month _____ day _____ year_____
Print Name of Parent Legal/Guardian_____
Parent Cell Phone Number: _____

F: Vaccination Record (FOR ADMINISTRATIVE USE ONLY):

Vaccine	**Date Dose Administered**	**Route**	**Lot Number**	**Name and Title of Vaccine Administrator**
2024 Seasonal Flu	/ /2024	L Arm R Arm ☐ IM		
Booster Dose	/ /2023	L Arm R Arm ☐ IM		

Dear Parent or Guardian: Please complete this SBHC Application and return them to the school nurse. Thank you.

HEALTH HISTORY FORM

This form is required by Ohio State law. Please complete, sign and return to the school health office as soon as possible.

CHILD'S NAME_____ **DOB**_____

SCHOOL _____ **GRADE**_____ **ROOM**_____

1. Is your child allergic to any medications? No_____ Yes_____
List:_____

2. Any food allergies? (Please list) _____

Any other allergies? (Latex, Environmental, Insect Bites/ Stings) (Please list)
_____

3. Does your child or any family member have or had any of these problems? (Please check)

	Child	Family		Child	Family		Child	Family
Abnormal spinal curvature	_____	_____	Acne	____	_____	Alcohol / Drug Abus	_____	_____
Allergies/hay fever	_____	_____	Anemia Or other blood problem	____	_____	Anaphylactic reaction	_____	____
Asthma or wheezing	_____	_____	Attention deficit disorder	____	_____	Behavior problems	_____	_____
Boys: Testicle not in sac	_____	_____	BM in Pants	____	_____	Broken Bones	_____	_____
Cancer - type _____	_____	_____	Chicken pox	____	_____	Chronic diarrhea or constipation	_____	_____
Chronic ear infections	_____	_____	Concussion	____	_____	Depression	_____	_____
Diabetes	_____	_____	Dizziness/ Light Headed	____	_____	Eczema/chronic skin infections	_____	_____
Elevated lead levels	_____	_____	Emotional/ Psychological problems	____	_____	Eye problems/ poor vision	_____	_____
Fainting with exercise	_____	_____	Frequent sore throats	____	_____	Frequent stomach aches	_____	_____
Frequent headaches	_____	_____	Heart murmur	____	_____	Hearing loss	_____	_____
Heart disease –	_____	_____	Hepatitis	____	_____	High/low blood pressure	_____	_____
High Cholesterol	_____	_____	HIV/Aids	____	_____	Hives	_____	_____
Hyperactivity	_____	_____	Kidney disease	____	_____	Lead Poisoning	_____	_____
Learning problems	_____	_____	Leukemia	____	_____	Lumps in groin/ breast	_____	_____
Migraines	_____	_____	Muscle/joint problems	____	_____	Nervous twitches or tics	_____	_____
Nightmares	_____	_____	Nose Bleed	____	_____	Overweight	_____	_____
Seizure disorder/epilepsy	_____	_____	Sickle cell disease	____	_____	Sinus trouble	_____	_____
Sleep problems	_____	_____	Snoring	____	_____	Speech problems	_____	_____

HEALTH HISTORY FORM, continued

Stomach ulcers	_____	_____	Stool soiling	____	_____	Stroke	_____	_____
Suicide	_____	_____	Toothaches/dental	____	_____	Tuberculosis	_____	_____
Underweight Problems	_____	_____	Urinary tract infections	____	_____	Vaginal Discharge	_____	_____
Wetting Day/ Night	_____	_____	Abuse/ Domestic Violence	____	_____	**Other:** _____		

Please explain any "Yes" answers:
_____
_____
_____
_____
_____

Please list any other health problems or illnesses:_____

Does your child see any specialist for items you checked above?
List:_____

4. Did your child have any of these problems?

Prematurity or birth weight under 5 lbs._____ Difficult delivery/ birth_____

Poor growth/slow development in infancy _____ Exposure to Drugs or alcohol during pregnancy _____

Other problems in infancy_____

5a. Does your child CURRENTLY take any medications? No _____ Yes_____
If Yes, name of medication(s):_____
_____

5b. Has your child taken any medication(s) in the past? No_____ Yes_____ List:_____
_____
_____

6a. Has your child had any operations, serious injuries or hospitalizations? No____ Yes_____
Explain:_____
_____

6b. Specifically, has your child had any heart surgery? No_____Yes_____
Explain:_____

7. Has your child ever been pregnant?
No_____ Yes_____ If yes, how many living children has your child given birth to?_____

8. Has your child been a victim of abuse? No_____ Yes_____ If yes, when _____

9. Does your child have any dental problems and/or toothaches? Yes_____ No_____

10. Is your child on any special diet or have special diet needs? Yes_____ No_____
Explain:
_____

11. Tuberculosis (TB) Risk Assessment
Is your child in contact with any of the following persons: immigrant from another country, someone diagnosed or treated for TB, incarcerated children or adults, HIV-infected, homeless, nursing home residents, institutionalized children or adults, illegal drug users, or migrant farm workers? No _____ Yes_____ If yes, please circle the type of contact your child has had and state when _____.

HEALTH HISTORY FORM, continued

Please circle yes or no below, and explain any yes answers on the line provided regarding your child:

Has been diagnosed or treated for TB? No Yes If yes, when: _____
Is an immigrant? No Yes If yes, from where: _____
Has traveled to another country? No Yes If yes, when and where: _____
Has ever been in jail or 20/20? No Yes If yes, when and where _____

12. School Concerns

Please circle yes or no below, and explain any yes answers on the line provided:

Does your child have any learning problems? No Yes
_____

Is your child in a special class (Special Ed)? No Yes
_____

Has your child repeated a grade? No Yes
_____

Does your child get into trouble often at school? No Yes
_____

What are your child's grades? (A, B, C, D, F, S, U/s) _____ Is this a change? Yes _____ No _____

13. Do you have any concerns you want the health care provider to address now?

_____
_____
_____

_____ _____
Parent/Guardian Signature (required) ***Date of Signature (required)***

Please return the completed SBHC Application pages 1-3 to your child's school to finish the enrollment process. You may keep the Private Policy for your records.

Thank you for your cooperation!

==========

"For Parents of Adolescents" – Please complete the additional section below:

For Adolescent Medical History: Has your adolescent child ever had?

STDs No	Yes	Sexual Activity No	Yes	Drug Use No	Yes
Exposure to Violence No	Yes	**Interest in Family Prevention Advice** No	Yes	Alcohol Use No	Yes
Do you feel safe? No	Yes	Do you feel sad all the time? No	Yes	Smoking or Tobacco Use No	Yes

WinMed Health Consent & Privacy Practices

Winton Hills Medical Center	WinMed at City West	WinMed at CAA
5275 Winneste Ave	1019 Linn St	1740 Langdon Farm Rd
Cincinnati, OH 45232	Cincinnati, OH 45203	Cincinnati, OH 45237
P513-242-1033/F513-242-2855	P513-233-7100/F513-407-3451	P513-631-7100/F513-417-8335

School-Based Health Centers

Bond Hill Academy● Winton Hills Academy ● Woodward Career Technical High School

Elmwood Place Elementary ● St. Bernard Elementary ● St. Bernard-Elmwood Place Jr./Sr. High

By signing this form, I am consenting to WinMed Health's uses and disclosures of my Protected Health Information (PHI) to carry out Treatment, Payment, & Operations (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, WinMed Health may decline to provide treatment to me.

Please check how you prefer to receive communications below

- Consent to Text or Call for Appointment Reminders & Communications

I consent for WinMed Health to communicate with me regarding appointments and health outreach by:

□ Call with appointment communications

□ Text with appointment communications

□ E-mail with appointment communications

□ All communications

- Consent to Obtain Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include medications purchased without using your health insurance. Also over-the-counter medications, supplements, or herbal remedies that you take on your own may not be included. I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form, you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues, such as depression.

By signing below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices if requested.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

WinMed Health Consent & Privacy Practices

Winton Hills Medical Center	WinMed at City West	WinMed at CAA
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Cincinnati, OH 45232	Cincinnati, OH 45203	Cincinnati, OH 45237
P513-242-1033/F513-242-2855	P513-233-7100/F513-407-3451	P513-631-7100/F513-417-8335

School-Based Health Centers

Bond Hill Academy● Winton Hills Academy ● Woodward Career Technical High School

Elmwood Place Elementary ● St. Bernard Elementary ● St. Bernard-Elmwood Place Jr./Sr. High

Al firmar este formulario, doy mi consentimiento para que WinMed Health use y divulgue mi información médica protegida (PHI) para llevar a cabo el tratamiento, el pago y las operaciones (TPO).

Puedo revocar mi consentimiento por escrito, excepto en la medida en que la práctica ya haya hecho divulgaciones en base a mi consentimiento previo. Si no firmo este consentimiento, WinMed Health puede negarse a brindarme tratamiento.

Por favor marque cómo prefiere recibir las comunicaciones a continuación

• Consentimiento para mensajes de texto o llamadas para recordatorios y comunicaciones de citas

Doy mi consentimiento para que WinMed Health se comunique conmigo con respecto a las citas y el alcance de la salud a través de:

□ Llamar con comunicaciones de cita

□ Texto con comunicaciones de cita

□ Correo electrónico con comunicaciones de citas

□ Todas las comunicaciones

• Consentimiento para obtener el historial de medicamentos

El historial de medicamentos del paciente es una lista de recetas que los proveedores de atención médica le han recetado. Una variedad de fuentes, incluidas farmacias y aseguradoras de salud, contribuyen a la recopilación de esta historia. La información recopilada se almacena en el sistema de registro médico electrónico de la práctica y se convierte en parte de su registro médico personal. El historial de medicamentos es muy importante para ayudar a los proveedores a tratar sus síntomas y/o enfermedades adecuadamente y evitar interacciones medicamentosas potencialmente peligrosas. Es muy importante que usted y su proveedor analicen todos sus medicamentos para asegurarse de que su historial de medicamentos registrado sea 100% preciso. Algunas farmacias no ponen a disposición la información del historial de recetas, y es posible que su historial de medicamentos no incluya los medicamentos comprados sin usar su seguro de salud. También es posible que no se incluyan los medicamentos de venta libre, los suplementos o los remedios a base de hierbas que toma por su cuenta. Doy mi permiso para permitir que mi proveedor de atención médica obtenga mi historial de medicamentos de mi farmacia, mis planes de salud y mis otros proveedores de atención médica.

Al firmar este formulario de consentimiento, le da permiso a su proveedor de atención médica para que recopile y comparta información de su farmacia y de su aseguradora médica sobre sus recetas que se surtieron en cualquier farmacia o que están cubiertas por cualquier plan de seguro médico. Esto incluye medicamentos recetados para tratar el SIDA/VIH y medicamentos utilizados para tratar problemas de salud mental, como la depresión.

Al firmar a continuación, reconozco que he recibido una copia del Aviso de prácticas de privacidad si se solicita.

_____ _____

Firma del paciente Fecha

_____ _____

Firma del padre/tutor Fecha

MERCYHEALTH

Parental Consent and Registration for Services
Mercy Health – Sayler Park School Health Center

☐ **Yes**, I give permission for my child to receive services provided by the Mercy Health Center at Mt. Washington School, a school-based health center (SBHC), and as determined by the Center's medical staff.

- The consent will remain in effect until my child is no longer enrolled in Mt. Washington or until I revoke consent in writing. It is my responsibility to notify the school about changes in legal guardianship.
- I understand that the SBHC will notify me about seeing/treating my child. This will be done by telephone or in writing.
- I authorize the SBHC and its staff to communicate with my child's doctor/clinic about care/services.
- I authorize the SBHC to bill my health insurance provider for services rendered.

Child/Patient's Name _____ **Date of Birth** _____ **SS #** _____
Last First Middle

School _____Mt. Washington School_____ **Grade** _____

Child/Patient's Sex_____ **Race/Ethnicity**_____

Parent Phone # _____ Cell # _____ Work # _____

Home Address _____City _____ State _____ Zip Code _____

Parent/Guardian's Name _____**Parent Date of Birth** _____ **Parent SS #** _____
Last First Middle

Child/Patient Allergies (including medications) _____

Emergency Contact (other than listed parent) _____ Relation_____ Phone #_____

Name of Primary Doctor or Clinic _____ Phone # _____

Preferred Pharmacy _____ Phone # _____

Would you like your child's annual well child exam completed at the SBHC? YES NO
Would you like your child's required immunizations completed at the SBHC? YES NO

Name of Health Insurance or HMO _____

If parent/guardian's policy, insured parent's name and date of birth_____

Medical Card or Insurance Member ID _____ (Please provide a copy of insurance card)

Confidentiality: The information in my child's medical record is confidential and will not be released to any unauthorized person or agency without my consent. However, I understand that at times it may be necessary for team members of the SBHC to confer amongst themselves and the school health assistant about health issues related to my child. I understand that, as a courtesy, a record of any service or care to my child at the SBHC will be forwarded to his/her family doctor or clinic. I understand that data not specific to an individual child may be used to evaluate the program.

Mercy Health – Sayler Park School Health Center

Signature of Parent or Legal Guardian _____

Date _____

Child Health History

Name of Child _____Date of Birth _____

Please provide the following information, which will help us provide health care to your child. All information will be kept confidential, in accordance with the HIPAA privacy rule.

Does your child take any daily prescribed medications? YES NO

If **YES,** please list_____

Does your child take any over-the-counter (OTC) medications regularly? YES NO

IF **YES,** please list_____

Please let us know your Child's health history by listing or checking off any of the chronic health conditions below:

__Asthma __Diabetes __Heart murmur/cardiac condition __Anemia __elevated Lead Level
__Seizures __ADHD __Depression __Anxiety

__Other Health Conditions-Please list:_____

Has your child had any operations, hospitalizations, or serious accidents? YES NO
If **YES**, please provide description, dates _____
_____

When was your child's last well check/annual exam? _____

Is your child up to date on immunizations? YES NO DON'T KNOW

Has your child's doctor recommended any restrictions of activity for your child?
YES NO If **YES**, please list restrictions _____

Please let us know your family's health history by listing or checking off any of the chronic health conditions below:

__Diabetes __Asthma __Heart Disease __Substance Abuse __Depression/Anxiety

__Other Health Conditions-Please list:_____

Please list all persons living in child's home and relationship to child

_____

_____

_____

_____

MERCYHEALTH

Parental Consent and Registration for Services
Mercy Health – Pleasant Hill School Health Center

☐ **Yes**, I give permission for my child to receive services provided by the Mercy Health Center at Mt. Washington School, a school-based health center (SBHC), and as determined by the Center's medical staff.

- The consent will remain in effect until my child is no longer enrolled in Mt. Washington or until I revoke consent in writing. It is my responsibility to notify the school about changes in legal guardianship.
- I understand that the SBHC will notify me about seeing/treating my child. This will be done by telephone or in writing.
- I authorize the SBHC and its staff to communicate with my child's doctor/clinic about care/services.
- I authorize the SBHC to bill my health insurance provider for services rendered.

Child/Patient's Name _____ **Date of Birth** _____ **SS #** _____
Last First Middle

School _____Mt. Washington School_____ **Grade** _____

Child/Patient's Sex_____ **Race/Ethnicity**_____

Parent Phone # _____ Cell # _____ Work # _____

Home Address _____City _____ State _____ Zip Code _____

Parent/Guardian's Name _____**Parent Date of Birth** _____ **Parent SS #** _____
Last First Middle

Child/Patient Allergies (including medications) _____

Emergency Contact (other than listed parent) _____ Relation_____ Phone #_____

Name of Primary Doctor or Clinic _____ Phone # _____

Preferred Pharmacy _____ Phone # _____

Would you like your child's annual well child exam completed at the SBHC? YES NO
Would you like your child's required immunizations completed at the SBHC? YES NO

Name of Health Insurance or HMO _____

If parent/guardian's policy, insured parent's name and date of birth_____

Medical Card or Insurance Member ID _____ (Please provide a copy of insurance card)

Confidentiality: The information in my child's medical record is confidential and will not be released to any unauthorized person or agency without my consent. However, I understand that at times it may be necessary for team members of the SBHC to confer amongst themselves and the school health assistant about health issues related to my child. I understand that, as a courtesy, a record of any service or care to my child at the SBHC will be forwarded to his/her family doctor or clinic. I understand that data not specific to an individual child may be used to evaluate the program.

Mercy Health – Pleasant Hill School Health Center

Signature of Parent or Legal Guardian _____

Date _____

Child Health History

Name of Child _____Date of Birth _____

Please provide the following information, which will help us provide health care to your child. All information will be kept confidential, in accordance with the HIPAA privacy rule.

Does your child take any daily prescribed medications? YES NO

If **YES,** please list_____

Does your child take any over-the-counter (OTC) medications regularly? YES NO

IF **YES,** please list_____

Please let us know your Child's health history by listing or checking off any of the chronic health conditions below:

__Asthma __Diabetes __Heart murmur/cardiac condition __Anemia __elevated Lead Level
__Seizures __ADHD __Depression __Anxiety

__Other Health Conditions-Please list:_____

Has your child had any operations, hospitalizations, or serious accidents? YES NO
If **YES**, please provide description, dates _____
_____

When was your child's last well check/annual exam? _____

Is your child up to date on immunizations? YES NO DON'T KNOW

Has your child's doctor recommended any restrictions of activity for your child?
YES NO If **YES**, please list restrictions _____

Please let us know your family's health history by listing or checking off any of the chronic health conditions below:

__Diabetes __Asthma __Heart Disease __Substance Abuse __Depression/Anxiety

__Other Health Conditions-Please list:_____

Please list all persons living in child's home and relationship to child

_____

_____

_____

_____

Crossroad Health Center & Taft Elementary/MAPA

Welcome & Enrollment Packet

School Based Health Center at Taft Elementary

STUDENT/PATIENT Name: _____ **Date of Birth** ___/___/___ **Male/Female**

Child's Social Security # _____-_____-_____ Insurance ID: _____

Insurance: ☐ CareSource ☐ Molina ☐ Buckeye ☐ Paramount ☐ United Health Care ☐ NO INSURANCE ☐ OTHER_____

Services Available through your School-Based Health Center

PRIMARY HEALTH CARE from Crossroad Health Center Provider at Taft Elementary:

YES, I consent for my child to receive MEDICAL CARE.

*May include treatment for acute illness or injury that occurs at school, referral to medical specialists, and may include administering over-the-counter medications unless emergency services are needed. SBHC care also includes routine well-child care (e.g. work, daycare, and sports physicals), and appropriate immunizations. (Note: well-child care includes vision / hearing screening, urine / blood tests, and an external genital exam, when appropriate.) ***Please note: In Ohio, minors may access confidential service for sexually transmitted infections and family planning, including provision of contraception such as condoms or birth control pills without parental consent.**

☐ NO, I do not wish for my child to receive MEDICAL CARE at the School-Based Health Center (SBHC)

DENTAL HEALTH CARE SERVICES:

YES, I consent for my child to receive DENTAL SERVICES from a Cincinnati Health Department (CHD) Clinic, affiliate or mobile clinic.

*May include preventive care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals. Most care will occur at school, however, some services may require transportation to an outside clinic. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, authorized agents and representatives, Crossroad Health Center, and the Cincinnati Public School District, its board members, administrators, employees, and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

☐ NO, I do not wish for my child to receive DENTAL SERVICES

VISION CLINIC SERVICES:

YES, I consent for my child to receive EYE CLINIC SERVICES at the OneSight Vision Center at Oyler School.

*Services may include comprehensive eye examinations including dilation, vision therapy, and the fitting / dispensing of vision correction. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, authorized agents and representatives, Crossroad Health Center, and the Cincinnati Public School District, its board members, administrators, employees, and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services. ☐ NO, I do not wish for my child to receive VISION SERVICES.

_____ _____ _____

Parent / Guardian Signature **Parent/Guardian Name** (PRINT) **DATE TODAY**

Phone (best) _____ Phone #2_____ Phone #3_____

_____ _____ _____

ADDRESS STREET APT CITY STATE ZIP

I agree to terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in Program Description form. I have also received and agree with the **Patient Consent for Use and Disclosure of Protected Health Information** as explained in the **Program Description** form. I have the option to review both the CHD and Crossroad's **Notice of Privacy Practices,** available at the nurse's office. **Consent in effect until terminated in writing** by Parent/Guardian.

WHY do we have a School Health Center & Nurse Practitioner?

We want to HELP:

- Keep your child out of the *emergency room* – unless absolutely necessary.
- Provide medical care – including diagnosis and prescriptions—if your child is sick at school.
- Reduce the trouble and time involved in taking your child to a doctor or urgent care.

Do you NEED a REGULAR DOCTOR for your children? We can help. Crossroad's Nurse Practitioner (NP) at Rothenberg can become your child's regular medical provider. This means your children can also be seen at the Crossroads Health Center, 5 E. Liberty Ave. in Over-the-Rhine, -- even when school is not open.

You are welcome to **KEEP your child's regular doctor.** The NP at school will communicate all care directly to your usual doctor.

Crossroad School-Based Health Center (SBHC) will **TRY TO CONTACT YOU immediately** if your child becomes sick or injured at school. Our medical staff will take appropriate action to keep your child safe and healthy during school hours. Please **NOTIFY SCHOOL** when you **CHANGE** phone numbers.

To provide health services for your child we need the following information:

Parent/Guardian Name: _____ Relationship to child: _____

Parent/Guardian's Date of Birth: _____/_____/_____ Your Social Security No: _____- _____- _____

Address:_____ City/State/ZIP_____

Phone Numbers to reach you: (1)_____ (2) _____ (3) _____

· **Emergency Contact Person:**_____ Phone(s):_____

PLEASE inform School Nurse or Office when you CHANGE PHONE NUMBER! We must be able to reach YOU in an Emergency.

· Regular **Medical Doctor** or Clinic: _____ Child's last "well child" exam: _____

· Regular **Dentist**/Clinic: _____ Date of last check-up: _____

· Preferred **Pharmacy:** _____

Do you want a copy of the physical exam to go to your clinic or doctor? □ **YES** □ **NO**

Your Child's Health History

1. **Is your child allergic to ANY medications?** □ No □ Yes Please list: _____
2. **Any SEVERE food or environment allergies?** Please list: _____
   *Does your child have an **Epi-Pen** for this allergic reaction?* □No □Yes
3. **Did your child have any of these problems?** □ Prematurity or birth weight under 5 lbs. □ Difficult delivery □ Poor/slow growth in infancy
4. **Does your child TAKE any medications NOW? or IN THE PAST?** □Yes Please provide name of medication and condition.

   _____
5. **Has your child had any operations, serious injuries, or hospitalizations?** □ Yes Please provide reason and dates.

   _____
6. **Has your child ever been pregnant?** □ No □ Yes If ***Yes***, how many living children has your child given birth to: _____
7. **Has your child been a victim of abuse?** □ No □ Yes

School Concerns: Explain any YES answers on the line provided.

Does your child have any LEARNING PROBLEMS?	□ YES	□ NO	_____
Is your child in a special class (Special Ed / IEP / 504 Plan)?	□ YES	□ NO	_____
Has your child repeated a grade?	□ YES	□ NO	_____
Does your child get into trouble often at school?	□ YES	□ NO	_____

What are your child's grades? _____ ***Is this a change?*** □YES □ NO

Does your CHILD or any FAMILY MEMBER have or had any of these HEALTH problems? (Please Check)

	CHILD	FAMILY		CHILD	FAMILY		CHILD	FAMILY
Asthma or wheezing	_____	_____	ADHD / Behavior	_____	_____	Allergies / Hay Fever	_____	_____
Cancer (type)	_____	_____	Concussion	_____	_____	Depression / Mental Illness	_____	_____
Diabetes	_____	_____	Drug / Alcohol Use	_____	_____	Eczema / Skin Problems	_____	_____
Headache / Migraines	_____	_____	Hearing Problems	_____	_____	Heart Disease	_____	_____
High Blood Pressure	_____	_____	Nosebleeds	_____	_____	Seizures	_____	_____
Sickle Cell Disease / Trait	_____	_____	Stroke	_____	_____	Urinary Tract Infections	_____	_____
Poor Vision / Blindness	_____	_____	Wetting/soiling self day or night	____	_____			

Other health concerns you may have about your child:

Tuberculosis (TB) Risk Assessment: Is your child in contact with any of the following persons: immigrants from another country, someone diagnosed or treated for TB, incarcerated children or adults, HIV-infected, homeless, nursing home residents, illegal drug users, or migrant farm workers? YES NO

Please **circle YES or NO** below.

Diagnosed or treated for TB?	YES	NO	Is an immigrant?	YES	NO
Traveled to another country?	YES	NO	Has ever been in jail or 20/20?	YES	NO

Crossroad Health Center & Rothenberg Elementary

Welcome & Enrollment Packet

School Based Health Center at Rothenberg Prep

city of CINCINNATI HEALTH DEPARTMENT
We know **health** matters

STUDENT/PATIENT Name: _____ **Date of Birth** ___/___/___ **Male/Female**

Child's Social Security # _____-_____-_____ Insurance ID: _____

Insurance: ☐ CareSource ☐ Molina ☐ Buckeye ☐ Paramount ☐ United Health Care ☐ NO INSURANCE ☐ OTHER_____

Services Available through your School-Based Health Center

PRIMARY HEALTH CARE from Crossroad Health Center Provider at Rothenberg Elementary:

YES, I consent for my child to receive MEDICAL CARE.

*May include treatment for acute illness or injury that occurs at school, referral to medical specialists, and may include administering over-the-counter medications unless emergency services are needed. SBHC care also includes routine well-child care (e.g. work, daycare, and sports physicals), and appropriate immunizations. (Note: well-child care includes vision / hearing screening, urine / blood tests, and an external genital exam, when appropriate.) ***Please note: In Ohio, minors may access confidential service for sexually transmitted infections and family planning, including provision of contraception such as condoms or birth control pills without parental consent.**

☐ NO, I do not wish for my child to receive MEDICAL CARE at the School-Based Health Center (SBHC)

DENTAL HEALTH CARE SERVICES:

YES, I consent for my child to receive DENTAL SERVICES from a Cincinnati Health Department (CHD) Clinic, affiliate or mobile clinic.

*May include preventive care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals. Most care will occur at school, however, some services may require transportation to an outside clinic. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, authorized agents and representatives, Crossroad Health Center, and the Cincinnati Public School District, its board members, administrators, employees, and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

☐ NO, I do not wish for my child to receive DENTAL SERVICES

VISION CLINIC SERVICES:

YES, I consent for my child to receive EYE CLINIC SERVICES at the OneSight Vision Center at Oyler School.

*Services may include comprehensive eye examinations including dilation, vision therapy, and the fitting / dispensing of vision correction. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, authorized agents and representatives, Crossroad Health Center, and the Cincinnati Public School District, its board members, administrators, employees, and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services. ☐ NO, I do not wish for my child to receive VISION SERVICES.

_____ _____ _____

Parent / Guardian Signature **Parent/Guardian Name** (PRINT) **DATE TODAY**

Phone (best) _____ Phone #2_____ Phone #3_____

_____ _____ _____

ADDRESS STREET APT CITY STATE ZIP

I agree to terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in Program Description form. I have also received and agree with the **Patient Consent for Use and Disclosure of Protected Health Information** as explained in the **Program Description** form. I have the option to review both the CHD and Crossroad's **Notice of Privacy Practices,** available at the nurse's office. **Consent in effect until terminated in writing** by Parent/Guardian.

WHY do we have a School Health Center & Nurse Practitioner?

We want to HELP:

- Keep your child out of the *emergency room* – unless absolutely necessary.
- Provide medical care – including diagnosis and prescriptions—if your child is sick at school.
- Reduce the trouble and time involved in taking your child to a doctor or urgent care.

Do you NEED a REGULAR DOCTOR for your children? We can help. Crossroad's Nurse Practitioner (NP) at Rothenberg can become your child's regular medical provider. This means your children can also be seen at the Crossroads Health Center, 5 E. Liberty Ave. in Over-the-Rhine, -- even when school is not open.

You are welcome to **KEEP your child's regular doctor.** The NP at school will communicate all care directly to your usual doctor.

Crossroad School-Based Health Center (SBHC) will **TRY TO CONTACT YOU immediately** if your child becomes sick or injured at school. Our medical staff will take appropriate action to keep your child safe and healthy during school hours. Please **NOTIFY SCHOOL** when you **CHANGE** phone numbers.

To provide health services for your child we need the following information:

Parent/Guardian Name: _____ Relationship to child: _____

Parent/Guardian's Date of Birth: _____/_____/_____ Your Social Security No: _____- _____- _____

Address:_____ City/State/ZIP_____

Phone Numbers to reach you: (1)_____ (2) _____ (3) _____

· **Emergency Contact Person:**_____ Phone(s):_____

PLEASE inform School Nurse or Office when you CHANGE PHONE NUMBER! We must be able to reach YOU in an Emergency.

· Regular **Medical Doctor** or Clinic: _____ Child's last "well child" exam: _____

· Regular **Dentist**/Clinic: _____ Date of last check-up: _____

· Preferred **Pharmacy:** _____

Do you want a copy of the physical exam to go to your clinic or doctor? □ **YES** □ **NO**

Your Child's Health History

1. **Is your child allergic to ANY medications?** □ No □ Yes Please list: _____
2. **Any SEVERE food or environment allergies?** Please list: _____
   *Does your child have an **Epi-Pen** for this allergic reaction?* □No □Yes
3. **Did your child have any of these problems?** □ Prematurity or birth weight under 5 lbs. □ Difficult delivery □ Poor/slow growth in infancy
4. **Does your child TAKE any medications NOW? or IN THE PAST?** □Yes Please provide name of medication and condition.

   _____
5. **Has your child had any operations, serious injuries, or hospitalizations?** □ Yes Please provide reason and dates.

   _____
6. **Has your child ever been pregnant?** □ No □ Yes If ***Yes***, how many living children has your child given birth to: _____
7. **Has your child been a victim of abuse?** □ No □ Yes

School Concerns: Explain any YES answers on the line provided.

Does your child have any LEARNING PROBLEMS?	□ YES	□ NO	_____
Is your child in a special class (Special Ed / IEP / 504 Plan)?	□ YES	□ NO	_____
Has your child repeated a grade?	□ YES	□ NO	_____
Does your child get into trouble often at school?	□ YES	□ NO	_____

What are your child's grades? _____ ***Is this a change?*** □YES □ NO

Does your CHILD or any FAMILY MEMBER have or had any of these HEALTH problems? (Please Check)

	CHILD	FAMILY		CHILD	FAMILY		CHILD	FAMILY
Asthma or wheezing	_____	_____	ADHD / Behavior	_____	_____	Allergies / Hay Fever	_____	_____
Cancer (type)	_____	_____	Concussion	_____	_____	Depression / Mental Illness	_____	_____
Diabetes	_____	_____	Drug / Alcohol Use	_____	_____	Eczema / Skin Problems	_____	_____
Headache / Migraines	_____	_____	Hearing Problems	_____	_____	Heart Disease	_____	_____
High Blood Pressure	_____	_____	Nosebleeds	_____	_____	Seizures	_____	_____
Sickle Cell Disease / Trait	_____	_____	Stroke	_____	_____	Urinary Tract Infections	_____	_____
Poor Vision / Blindness	_____	_____	Wetting/soiling self day or night	____	_____			

Other health concerns you may have about your child:

Tuberculosis (TB) Risk Assessment: Is your child in contact with any of the following persons: immigrants from another country, someone diagnosed or treated for TB, incarcerated children or adults, HIV-infected, homeless, nursing home residents, illegal drug users, or migrant farm workers? YES NO

Please **circle YES or NO** below.

Diagnosed or treated for TB?	YES	NO	Is an immigrant?	YES	NO
Traveled to another country?	YES	NO	Has ever been in jail or 20/20?	YES	NO

Office use only

Cincinnati Children's
changing the outcome together

School Based Health Center Consent to Treat

Name: _____
DOB: _____
MRN: _____

Patient Information

Patient Name: _____ Gender: Male Female Other
Last First Middle

Address: _____

Date of Birth: _____ Phone: ( ) _____ Grade: _____

Parent/Person Completing Form: _____

Notice

I understand that Cincinnati Children's Hospital Medical Center operates the school-based health center in my/my child's school. I allow Cincinnati Children's to give care and treatment to me/my child at the school-based health center. I am authorized by law to give consent for my child. This consent is in place until it is removed by me in writing. I understand that CCHMC may take photographs, films, or audiovisual recordings ("images") of the patient to use for diagnosis, treatment, identification of the patient and internal purposes such as staff training, medical education, performance improvement, and other organizational activities. CCHMC may provide certain services utilizing telehealth technology, including transmission of images, video and audio that are encrypted for privacy. The remote provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription for myself/my child. I understand that I/my child may have to travel to see a health provider in-person for certain diagnosis and treatment or in the event of a technical failure. I have received a copy of Cincinnati Children's Notice of Privacy Practices. Cincinnati Children's may use or share health or personal information about me/my child as stated in the Notice. This consent allows Cincinnati Children's to access and review me/my child's medical record information from previous providers at the Center, including Neighborhood Health Care, Inc. Please apply any insurance benefits to Cincinnati Children's for services performed.

Signature of Patient: _____ Date: _____
(if 18 years of age or older OR is an emancipated minor)

Signature of Parent Person Authorized to Consent (check one): _____ Date: _____

_____ By initialing here, I agree that my typed signature is the same as my handwritten signature for this consent.

_____ By initialing here, I have gotten the Notice of Privacy Practices.

Submit

Please make sure that all sections are completed. Then, please **return the form to your School-Based Health Center location or email it to SchoolBasedHealthClinics@cchmc.org.**

Please check your School-Based Health Center location: Hughes Rockdale South Avondale

Parent/Person Authorized to Consent Name: _____

Relationship to Child: _____ Parent/Person Authorized to Consent Date of Birth: _____

Address: _____

Primary Phone Number: ( ) _____ Additional Phone Number: ( ) _____

Emergency Contact Person Name & Phone: _____

Child's Doctor/Clinic: _____ Child's Dentist: _____

Preferred Pharmacy: _____

School Based Health Center Consent to Treat

Name: _____

DOB: _____

MRN: _____

What type of insurance do you have for your child? Check all that apply:

	Insurance Provider	Insurance Number	
	Medicaid	MMIS #	Member #
	Healthy Start/Healthy Families (CHIP)		
	Private Insurance (List below):		
	1.		
	2.		
	3.		

Get Support with Parent Advocacy Hours

Are you looking for support or assistance navigating CPS?

We are now offering virtual office hours with CPS' District Parent Champion, LaRonda Thomas.

Appointments are 15 minutes and give you space to ask questions, discuss any concerns or how CPS can support you and your child.

Parent Advocacy Office Hours:

Mondays and Wednesdays
10:00 a.m. - 11:00 a.m.
2:00 p.m. - 3:00 p.m.
6:00 p.m. - 7:00 p.m.

Please contact LaRonda Thomas to schedule an appointment at **parentvoice@cps-k12.org** or **513-377-2167.**
Interpreter Services available

CINCINNATI PUBLIC SCHOOLS | PARENT VOICE #activateyourvoice

Join a Parent Organization!

Make a difference at your student's school! Join a Parent Organization today!

School Parent Organizations give you the opportunity to:

1. Activate your voice
2. Support your students' academic and social-emotional success
3. Share your expertise
4. Build community
5. Learn and have fun!

Contact your school's Parent Chair or School Resource Coordinator for more information

Create a Parent Organization at Your School!

Help us reach our goal of 65 parent organizations by 2025! Contact LaRonda Thomas, CPS Parent Champion, for information on establishing or becoming involved in a Parent Organization at your school!

To learn more visit
https://bit.ly/parentresources

Email ParentVoice@cps-k12.org
Join our Parent Commnutiy on Facebook
https://bit.ly/CPSParentVoiceGroup

Parent Engagement Form

Welcome New & Returning Parents, Guardians and Caregivers! Would you like to volunteer at your child's school?

Fill out the survey online by visiting https://bit.ly/ParentEngagementSurveySY23 or scanning the QR code.

If you complete the paper form, please return it to the main office at your child's school.

Student Information

Name: _____

Grade: _____

School: _____

Parent / Guardian / Caregiver Information

Name: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-mail: _____

Best time and /or day for volunteering:

Monday_____ Tuesday_____ Wednesday_____ Thursday_____ Friday_____

Please share your skills and areas of interest for volunteering. For example, tutoring, chaperone, office assistant or classroom guest speaker and topics.

_____

_____

_____

_____

_____

_____

Are you registered to vote?

Registering to vote or updating your address for voting is easy — you can go online, print a form and mail it in, or go in person to any public library or Ohio BMV.

Check your registration status or register now at **https://votehamiltoncountyohio.gov/register/**

To vote in the **August 5, 2024** Special Election, you must register by **July 7, 2024**.

To vote in the **November 4, 2024** General Election, you must register by **October 6, 2024**.

Voter Registration and Information Update Form

Please read instructions carefully. Please type or print clearly with blue or black ink.
For further information, you may consult the Secretary of State's website at: VoteOhio.gov or call 877-SOS-OHIO (877-767-6446).

Eligibility

You are qualified to register to vote in Ohio if you meet all the following requirements:

1. You are a citizen of the United States.
2. You will be at least 18 years old on or before the day of the general election.
3. You will be a resident of Ohio for at least 30 days immediately before the election in which you want to vote.
4. You are not incarcerated (in jail or in prison) for a felony conviction.
5. You have not been declared incompetent for voting purposes by a probate court.
6. You have not been permanently disenfranchised for violations of election laws.

Use this form to register to vote or to update your current Ohio registration if you have changed your address or name.

NOTICE: This form must be received or postmarked by the 30th day before an election at which you intend to vote. You will be notified by your county board of elections of the location where you vote. If you do not receive a notice following timely submission of this form, please contact your county board of elections.

Please see information on back of this form to learn how to obtain an absentee ballot.

Numbers 1 and 2 below are required by law. You must answer both of the questions for your registration to be processed.

Identification Requirements

If you have a current Ohio driver's license or state ID card, you must provide that number on line 10. If you do not have an Ohio driver's license or state ID card, you must provide the last four digits of your Social Security number on line 10. If you have neither, please write "None."

Residency Requirements

Your voting residence is the location that you consider to be a permanent, not a temporary, residence. Your voting residence is the place in which your habitation is fixed and to which, whenever you are absent, you intend to return. If you do not have a fixed place of habitation, but you are a consistent or regular inhabitant of a shelter or other location to which you intend to return, you may use that shelter or other location as your residence for purposes of registering to vote. If you have questions about your specific residency circumstances, you may contact your local board of elections for further information.

Your Signature

In the area below the arrow in Box 14, please write your cursive, hand-written signature or make your legal mark, taking care that it does not touch the surrounding lines so when it is digitally imaged by your county board of elections it can effectively be used to identify your signature.

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE

I am: ☐ **Registering as an Ohio voter** ☐ **Updating my address** ☐ **Updating my name**

1. Are you a U.S. citizen? ☐ **Yes** ☐ **No**

2. Will you be at least 18 years of age on or before the next general election? ☐ **Yes** ☐ **No**

If you answered NO to either of the questions, do not complete this form.

3. Last Name	First Name	Middle Name or Initial	Jr., II, etc.

4. House Number and Street (Enter new address if changed)	Apt. or Lot #	5. City or Post Office	6. ZIP Code

7. Additional Mailing Address (if necessary)	8. County (where you live)

9. Birthdate (MM/DD/YYYY) (required)	10. Ohio driver's license number, state ID card number, OR last four digits of Social Security number (one form of ID required to be listed or provided)	11. Phone Number (voluntary)

12. **PREVIOUS ADDRESS IF UPDATING CURRENT REGISTRATION** - Previous House Number and Street

Previous City or Post Office	Previous County	Previous State

13. **CHANGE OF NAME ONLY** Former Legal Name	Former Signature

14. I declare under penalty of election falsification I am a citizen of the United States, will have lived in this state for 30 days immediately preceding the next election, and will be at least 18 years of age at the time of the general election.

Your Signature ↓ **Date** (MM/DD/YYYY) _____

FOR BOARD USE ONLY
SEC4010 (rev. 2/7/23)

City, Village, Twp.

Ward

Precinct

School Dist.

Cong. Dist.

Senate Dist.

House Dist.

TO ENSURE YOUR INFORMATION IS RECEIVED, PLEASE DO THE FOLLOWING:

1. Print this form.
2. Make sure all required fields are complete.
3. Sign and date your form.
4. Fold and insert your form into an envelope.
5. Mail your form to your county board of elections.

Board of Elections – Hamilton County Ohio
Registration Department
4700 Smith Rd. Cincinnati OH 45212

If you have additional questions, please call the office of the Ohio Secretary of State at 877-SOS-OHIO (877-767-6446).

HOW TO OBTAIN AN OHIO ABSENTEE BALLOT

You are entitled to vote by absentee ballot in Ohio without providing a reason. Absentee ballot applications may be obtained from your county board of elections or from the Secretary of State at: VoteOhio.gov or by calling 877-SOS-OHIO (877-767-6446).

OHIO VOTER IDENTIFICATION REQUIREMENTS

Voters must bring photo identification to the polls in order to verify identity. Voters who do not provide identification will still be able to cast a provisional ballot pursuant to R.C. 3505.181. For more information on voter identification requirements, please consult the Secretary of State's website at: VoteOhio.gov or call 877-SOS-OHIO (877-767-6446).

WHOEVER COMMITS ELECTION FALSIFICATION IS GUILTY OF A FELONY OF THE FIFTH DEGREE.

2025-2026 Calendar

August

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

September

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	**15M**	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

October

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	**17Q**	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

November

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	**17M**	18	19	20	21	22
23	24	25	26C	27	28	29
30						

December

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	**19Q**	20
21	22	23	24	25	26	27
28	29	30	31			

January

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

February

Su	Mo	Tu	We	Th	Fr	Sa
1	**2M**	3	4	5	6	7
8	9C	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

March

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	**13Q**	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

April

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	**13M**	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

May

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	**28Q**	29	30
31						

June

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

July

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

First day of school/last day of school

Teacher classroom workday-**NO STUDENTS**

PD day--**NO STUDENTS**

Holiday/Break - **All of CPS is Closed**

Holiday/Break -**Schools Closed**

C Teacher Conference Exchange Days (11.26 & 02.09)

Summer School-- **June 1-30**

Q End of Quarter

M Midterm Week

Notes:

171	Student Days
191	Teacher Days
1050-1137.5	Instructional Hours

* CPS Staff: Please review payroll calendars for additional details regarding paid holidays and schedule.

2025-26 Calendar Dates and Details

Aug 13-14	Teacher Classroom Workday*
Aug 15	Professional Development Day*
Aug 18	Professional Development Day*
Aug 19	Building Professional Meeting Day*
Aug 20	First Day of School for Students
Sept 1	Labor Day Holiday - Schools Closed/Central Office Closed
Sept 15	Midterm Week
Sept 22	District Professional Development Day - **No Students***
Oct 2	Teacher classroom workday-**No Students***
Oct 17	End of First Quarter (40 Instructional Days, 48 Staff Days)
Nov 4	Election Day - Only Schools Closed*
Nov 11	Veterans' Day Holiday - Schools Closed/Central Office Closed
Nov 17	Midterm Week
Nov 24	Holiday/Break - Only Schools Closed*
Nov 25	Holiday/Break - Only Schools Closed*
Nov 26	Holiday/Break - Only Schools Closed - Teacher Conference Exchange Days*
Nov 27	Thanksgiving Day Holiday - Schools Closed/Central Office Closed
Nov 28	Holiday/Break - Schools Closed/Central Office Closed*
Dec 19	End of Second Quarter (43 Instructional Days, 47 Staff Days)
Dec 22-Jan 2	Winter Recess - Only Schools Closed (10 days)*
Dec 24-25	Christmas Eve and Christmas Day Holiday-Schools Closed/Central Office Closed*
Jan 1	New Year's Day Holiday-Schools Closed/Central Office Closed
Jan 5	District Professional Development Day - **No Students***
Jan 6	Schools Reopen
Jan 19	Martin Luther King Jr. Day Holiday - Schools Closed/Central Office Closed
Feb 2	Midterm Week
Feb 9	Holiday/Break - Only Schools Closed - Teacher Conference Exchange Days*
Feb 16	Presidents' Day Holiday - Schools Closed/Central Office Closed
Mar 2	District Professional Development Day - **No Students***
Mar 13	End of Third Quarter (45 Instructional Days, 51 Staff Days)
Mar 23-27	Spring Break - Only Schools Closed (5 days)*
Mar 30	Schools Reopen
Apr 13	Midterm Week
May 25	Memorial Day Holiday - Schools Closed/Central Office Closed
May 28	End of Fourth Quarter - Last day for Students (43 Instructional Days, 45 Staff Days)
May 29	Teacher Classroom Workday - Last day for Teachers*
June 19	Juneteenth Holiday - Schools Closed/Central Office Closed
July 3	Independence Day Holiday - Schools Closed/Central Closed


CINCINNATI PUBLIC SCHOOLS