

MORGAN LOCAL SCHOOLS

65 WEST UNION AVENUE
P.O. BOX 509
McCONNELSVILLE, OH 43756



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MORGAN LOCAL SCHOOL DISTRICT REGISTRATION INFORMATION FORM

Date _____

To: Parent/Guardian of _____ Grade _____

We were happy to register your child in the Morgan Local School District today. During the registration process the following information and documents were discussed or verified by _____:

Name of person enrolling child

- Certified Birth Record (you have 90 days to provide this document)
- Custody Documents (If applicable)*
- Open Enrollment Approval (if applicable)*
- Photo ID of Parent or Guardian
- Immunization Record
- Proof of Residency
- IEP/504 (only need verification that student has one if coming from outside district)

*Starred items are mandatory prior to the registration being complete. You will have 2 weeks (14 days) to provide any of the missing information marked above to the school of attendance. Failure to provide missing information may result in law enforcement and Children's Services being contacted, and child excluded from further attendance in Morgan Local Schools.

Again, thank you for your cooperation. We look forward to having your child in our school district.

Your student's start date maybe determined at the time of registration. Morgan Local School District must give the building at least one day's prior notice to the student's first day of school. This allows for busing arrangements, class placement, text and materials to be ready when the student arrives. (In the event where student absence is an issue, this day of registration shall be counted as a transition day and the student will NOT be counted absent for purposes of perfect attendance.)

Proud of Our Past, Focused on Our Future

Student ID # _____



MORGAN LOCAL SCHOOL DISTRICT KINDERGARTEN REGISTRATION FORM**



**** Must be 5 years old on or before the first day of school**

CHECK WHICH ATTENDANCE BUILDING YOU LIVE

EAST WEST SOUTH

Will you be applying for a transfer to another elementary building? **YES*** _____ **NO** _____ *If yes, you must apply at the

If you do not live in the Morgan Local School District, which District? _____ Central Office by May 29th

STUDENT INFORMATION

Legal Last Name		Legal First Name		Legal Middle Name	
Nickname (if applicable)		Gender (M/F)	Birthdate (mm/dd/yyyy)		Age
Birthplace: City		State			

IS YOUR PRIMARY RACE HISPANIC/LATINO? **YES** _____ **NO** _____

STUDENT ETHNICITY: (Check all that apply)

Asian Native Hawaiian/other Pacific Islander American Indian/Alaskan Native Black/African American White/Caucasian

What language did your student speak when first learning to talk? _____ What language does your student speak at home? _____

What language do you use most when speaking to your student? _____ What language do the adults in your home use? _____

PRIMARY HOUSEHOLD INFORMATION - RESIDENT ADDRESS - WHERE STUDENT RESIDES

Street		Apt/Lot #		Home Phone	
City		State		Zip	

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)

Street		Apt/Lot #		Home Phone	
City		State		Zip	

Is there is a custody order pertaining to this child? **YES** _____ **NO** _____

Who has custody? _____

*****We must have a copy of the legal custody papers on file*****

Student's Natural Parents: Married Never Married Separated Divorced Other (specify) _____

If a Foster Child: School District of Residence _____

*****Student must have proper authorization to reside with grandparents or other relative*****

PREVIOUS SCHOOL INFORMATION

Has your child ever attended Pre School? **YES** _____ **NO** _____

If Yes, where? Headstart Play and Learn Stay N Play East South West Other

If Other, what is the name? _____ How Long did child attend Preschool? ___ 0-11 months _____ 12 months or more

Has your child ever attended Kindergarten? **YES** _____ **NO** _____ *If YES, where did they attend? _____

PARENT/GUARDIAN SIGNATURE

The information that I have supplied on this form is true and accurate as of this date. I understand that falsification of information to achieve enrollment or assignment may be cause for revocation of the student's enrollment or assignment to a school in Morgan Local School District

Signature _____

Relationship to Student _____

Date _____

Parents have the right to request and inspect the Cumulative Record on file for their child.

RESIDENTIAL PARENT (S) /GUARDIAN (S)

Name	Name
Relationship to Student	Relationship to Student
School District of Residence	School District of Residence
Cell Phone	Cell Phone
Work Phone	Work Phone
Email Address	Email Address
Is Parent/Guardian a member of Armed Forces?	<input type="checkbox"/> NO <input type="checkbox"/> YES If YES, which branch:
Are there any other people living in your household?	<input type="checkbox"/> NO <input type="checkbox"/> YES If YES, please complete the section below:

OTHER HOUSEHOLD MEMBERS

Name	Grade	School	Relationship

Current Housing: Relative/Friend Shelter Hotel/Motel Car Campsite Transitional
 Unaccompanied Foster Care Rent/Own Other _____

SECOND HOUSEHOLD MAILING INFORMATION (ONLY if different from primary address)**NON-HOUSEHOLD PARENT(S)/GUARDIAN(S)**

Name	Custody: YES _____ NO _____		
Address	City	State	Zip
Home Phone	Cell Phone		
Work Phone	Relationship to Student		
Email Address			

SPECIAL EDUCATION NEEDS

Has your child had a psychological evaluation, multi-factored evaluation, or other evaluation? YES _____ NO _____

Has your child been enrolled in any special education programs? If yes, please check the programs below:

- | | | |
|-----------------------------------|---|---|
| <input type="checkbox"/> 504 Plan | <input type="checkbox"/> Emotionally Disturbed | <input type="checkbox"/> Visually Impaired |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Blind | <input type="checkbox"/> Specific Learning Disability | <input type="checkbox"/> Cognitive Disability |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Multiple Disability | <input type="checkbox"/> Traumatic Brain Injury |
| | <input type="checkbox"/> Orthopedically Handicapped | <input type="checkbox"/> Other Health Impaired |

Other Program: Please describe the program: _____

Does your child have a **current IEP** (Individual Education Plan)? YES _____ NO _____

If yes, do you have a copy?

GIFTED SERVICES

Has your student been identified in any subject as Gifted? YES _____ NO _____

What subject area(s)? Creative Thinking Ability _____ Mathematics _____ Reading _____
 Science _____ Social Studies _____ Superior Cognitive Thinking _____ Visual/Performing Arts _____

For School Personnel Use only!!

Enrollment approved by: _____ Date _____

If Open Enrolled: Approved Denied Date Letter Sent _____

Documents Verified at Registration: By _____
 _____ Certified Birth Record Photo ID of Parent/Guardian
 _____ Custody Documents (if applicable) Proof of Residency
 _____ Immunization Record IEP/504 (only need verification that one exists if coming from outside district)

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
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Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly explain illness or problems. <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/>
How does the child's development compare to other children, such as his or her brothers/sisters or playmates? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced

Student Health Conditions

<input type="checkbox"/> YES , my child receives regular medical/health care for the following conditions:			<input type="checkbox"/> NO medical conditions		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia			
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions			
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems			
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury			
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)			
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Other _____			

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

Yes No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

Yes No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date / /
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Appendix A: Language Usage Survey

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

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

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



PR-10 PARENTAL CONSENT TO SHARE HEALTH INFORMATION FOR THE OHIO MEDICAID SCHOOL PROGRAM

CHILD'S INFORMATION

CHILD'S NAME _____

DATE OF BIRTH ____/____/____ DISTRICT NAME _____

Ohio school districts have the opportunity to receive federal Medicaid dollars through a program called the Ohio Medicaid School Program (MSP). Through this program, school districts can receive Medicaid dollars for therapy services such as Speech, Audiology, Physical Therapy, Occupational Therapy, Nursing, Psychology, Counseling, and Social Work services. In the process of billing Medicaid for these services, billing information must be shared with the Ohio Department of Medicaid. For Medicaid billing purposes, schools must obtain a one-time signed Parental Consent to Share Health Information for the Ohio School Medicaid Program. After this one-time written consent, you will receive an annual notice of this consent.

Schools request this consent for all students who receive therapy services, even students who may not be currently enrolled in Medicaid. Some health information shared is specific to your student, while other information is related to all students within the entire school district. Schools can use this health information to help reduce costs for services that the district must deliver pursuant to the Individuals with Disabilities Education Act (IDEA). This student specific health information is protected and will be accessed only by people authorized to do so by the school's Medicaid contract.

Your consent is voluntary. You have the right to withdraw your consent at any time (34 CFR Part 99 and Part 300.) You are not required to enroll in Medicaid. If your school does bill Medicaid, you will not be required to incur any out-of-pocket expenses such as a deductible or co-pay, decreased lifetime coverage, increased premiums or the discontinuation of benefits, or result in you paying for services.

Regardless of whether you grant consent, refuse consent, or revoke your consent, your child will still be provided with an evaluation and/or the services as identified by the school district at no cost to you.

____ I understand and agree to give permission to share my child's *specific* health information in order for the school to access Medicaid.

____ I do not give permission to share my child's *specific* health information in order for the school to access Medicaid.

Parent (printed) Name _____

Parent Signature _____

Date ____/____/____

Please contact **Healthcare Billing Services, Inc.** at (740) 639-4218 with questions or if you feel you have incurred a personal cost for these services.



Application for Youth Library Card

(Valid at both Kate Love Simpson Library locations)

Please Print Clearly

Date _____

Name of Youth _____
Last First Middle Initial

Mailing Address _____
City State

Zip Code _____ Preferred Phone Number () _____

E-mail address _____

Would you prefer to receive library notices by:

Mail Phone Email Text Message Email & Text Message

Complete Birth Date _____ month/day/year

I accept full responsibility for the care of all materials borrowed with this library card. I agree to obey all rules of the library, to pay for damaged and/or lost item fees charged to my library card and to give prompt notice of loss of the card or of any change to my address or phone number to KLS.

☆ **Print Parent/Guardian Name** _____

☺ **Parent/Guardian Signature** _____

☺ **Parents, please fill out the back of this page for movie and Internet options & policies.** ☺

• **PARENTAL PERMISSION REGARDING MOVIES, videos, audio books, CDs and DVDs**



My minor child, named on the reverse side, **has my permission to borrow only movies, videos, DVD's, audio books, or CD's shelved in the Children's Department.** These materials have G and PG ratings.

My minor child, named on the reverse side, **has my permission to borrow any movie, video, DVD, CD, or audio book in the entire library.** I recognize that many of these videos are not G or PG. I acknowledge that it is the responsibility of the parent, not the library, to monitor the suitability of all materials for my child.

Date _____

Parent/Guardian (print) _____

Parent/Guardian (signature) _____

• **PARENTAL PERMISSION for the INTERNET and USE OF COMPUTERS**

As parent/legal guardian, I accept full responsibility for supervising my child's use of the library's Internet/OPLIN workstations. I have received a copy of *Guidelines for Use of OPLIN* and _____ [child's name] has my permission to access the Internet/OPLIN with or without my presence.



I understand that it is impossible to guarantee that my child will not access inappropriate, controversial, and/or unlawful sites.

Neither the library nor its staff assumes any responsibility for any material accessed and will not be held liable for such material. It is solely the responsibility of the child and his/her parent to assume that responsibility.

I understand that my child may use a computer at KLS for only 2 hours per day. Specific school or work related assignments may extend the use of a computer if [a] computers are available [b] no games or personal internet activities occur during the initial computer use or the extended time. If my child prints from the computer, I agree to pay ten cents per page for standard prints and twenty-five cents per page for color printing. **Only children with their own valid library card will be permitted to use a library computer.**

If children or adults do not follow these guidelines, they will be asked to leave the library and will have their computer privileges revoked for one week. A second occurrence will result in a 4-week suspension of privileges. **Parents or guardians will be required to meet with library personnel before the child returns to the library.** If a third violation of these computer policies occur, patrons may permanently lose computer privileges.

Parent/Guardian (print) _____

Parent/Guardian (signature) _____

Date _____

Staff Signature _____