WELCOME TO
JACKSON PUBLIC SCHOOLS
Y5/K – 8 Grade Enrollment Packet

STUDENT NAME_____

PARENT/GUARDIAN NAME_____

HOME SCHOOL_____

Thank you for choosing Jackson Public Schools for your child's education. When you have completed the attached paperwork, please return to the school office.

Any questions, please call (517) 841-2147 (Curriculum Office) or the schools listed below.

	Phone #	**Fax #**
Cascades Elementary (Y5-5)	517-841-3900	517-768-5902
Dibble Elementary (K-5)	517-841-3970	517-768-5903
Hunt Elementary (Y5-5)	517-841-2610	517-768-5900
John R. Lewis Elementary (Y5-5)	517-841-2600	517-789-8056
JPS Montessori Center (K-5)	517-841-3870	517-990-0370
Northeast Elementary (Y5-5)	517-841-2500	517-768-5911
Sharp Park Academy (Y5-5)	517-841-2860	517-784-1325
Middle School at Parkside (6-8)	517-841-2300	517-768-5968

KINDERGARTEN:

- To be eligible for kindergarten, your child must be five years old on or before **September 1, 2026.**
- If your child needs a kindergarten assessment, you will be contacted by your school.

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Jackson Public Schools

Registration Checklist (Y5/K – 8th Grade)

We are excited that you have chosen to enroll your child into Jackson Public Schools! We wish to make the registration process as easy as possible as we begin to transition your child into his/her new school.

In addition to the attached packet, the following items are REQUIRED for enrollment:

- ☐ **Birth Certificate** – Copy of birth certificate OR other reliable proof of identity along with Inability to Provide Birth Certificate / Student Age & Identity Form (available in the school office).
- ☐ **Immunization Record** – According to State law, we will need proof of all your child's immunizations. If you are not certain your child is up to date with immunizations, please contact your family practitioner.
- ☐ **Proof of Residency Verification** – Two valid forms of proof of residency (refer to attached Residency Verification for acceptable items).
- ☐ **Proof of Custody** – *If custody arrangements for the child are applicable*, we need a copy of the most current custody paperwork. If documents exist that include adoption certificates or legal name changes, please have custody papers.
- ☐ **Special Education** – *If your child has received special education services*, such as speech, occupational therapy, physical therapy, resource room, etc., a copy of the most recent IEP or 504 Plan is essential.

Attached Forms

- ☐ **Registration/Emergency Contact**
- ☐ **Residency Verification** – This will verify that you live in our school district. Please refer to the Residency Verification for valid forms of proof of residency.
- ☐ **Vision-Hearing-Dental Screening** – Free screenings offered through the Jackson County Health Department.
- ☐ **McKinney-Vento Questionnaire** – Required information to comply with the McKinney-Vento Act.
- ☐ **Home Language Survey** – Required information to comply with Federal and State Law.
- ☐ **Concussion Awareness Acknowledgement**– The State of Michigan requires all parents of students enrolled in physical education classes and/or athletics to be informed of the symptoms of concussions.
- ☐ **Student Technology Use Agreement/JPS Device Contract** – Ensures appropriate use of technology while enrolled in the District.
- ☐ **Student Health Information** – Information used to help the school administrator medication(s) to your student.
- ☐ **Jackson Saves Enrollment** – *For Young 5's/Kindergarten Students ONLY.*
- ☐ **Release of Information** – *For Young 5's/Kindergarten Students ONLY.*
- ☐ **Oral Health Assessment** – *For Young 5's/Kindergarten Students ONLY; completed by licensed dental professional and returned to office.*

Thank you for helping us to make the registration process as efficient as possible by bringing the information listed above. Please do not hesitate to call if you have any questions, or if we can assist you in this process.

Cascades Elementary	517-841-3900
Dibble Elementary	517-841-3970
Hunt Elementary	517-841-2610
John R. Lewis Elementary	517-841-2600
JPS Montessori Center	517-841-3870
Northeast Elementary	517-841-2500
Sharp Park Academy	517-841-2860
Middle School at Parkside	517-841-2300

Updated 01/30/2026

Today's Date: _____

Start Date: _____

Grade: _____

Student Number: _____

Jackson Public Schools
Registration Form

Notes:

Office Use Only ____ New Enrollment ____ RE-enrollment JPS ___ In District Transfer ____ School of Choice

Bus Route: _____ Bus Stop: _____

_____ Birth Certificate _____ Immunization Record

Instructions:

Fill this enrollment form out to the best of your ability. Required fields are marked with an asterisk *.

Student Information			
*Student Name *(as it appears on birth certificate - first, middle, last)*			
*Gender *Circle one*	Male	Female	
*Date of Birth *(must match birth certificate)*			
*Is this student Hispanic/Latino? *Circle one*	No, not Hispanic/Latino	Yes, Hispanic/Latino	
*Ethnicity *(if more than one, circle all that apply)*	American Indian/Alaskan Native	Asian	Black/African American
	Native Hawaiian/Pacific Islander	White	
*Student Home Phone			
*Name of Parent/Guardian Student Lives With:		Relationship:	
Name and address of last school attended			
Student Address *(where student lives)*			
*Home Street Address		Apt #	
*Home City	State	Zip	
Mailing Address *(where school/district mailings will be sent)* ***- only fill out if different from above***			
*Mailing Street Address or PO Box		Apt #	
*Mailing City	State	Zip	
Residency Information			
_____ Resident _____Non Resident _____ District of Residence			
____ School of Choice Student Has student ever attended JPS? Yes / No If yes, when? _____			
Has student ever been enrolled in an Early College Program? Yes / No If yes, at what school? _____			
Special Education Information			
Does your child currently receive special education services? Yes / No			
If yes, does your child have an active IEP? Yes / No If yes, what is your child's certification? _____			

continued on next page

Contact information only - Emergency information will be on another form

Parent/Guardian 1		
Name	Relationship	
Home Phone	Receive automated messages on this number? _____ Yes	
Work Phone	Receive automated messages on this number? _____ Yes	
Cell Phone	Receive automated messages on this number? _____ Yes	
Email	Receive automated messages at this email address? _____ Yes	
Mailing Address/PO Box		
Mailing City, State, Zip		
Employer		
Receive Separate Mailings? Yes / No	Legal Guardian? Yes / No	Custodial Parent/Guardian? Yes / No
Parent/Guardian 2		
Name	Relationship	
Home Phone	Receive automated messages on this number? _____ Yes	
Work Phone	Receive automated messages on this number? _____ Yes	
Cell Phone	Receive automated messages on this number? _____ Yes	
Email	Receive automated messages at this email address? _____ Yes	
Mailing Address/PO Box		
Mailing City, State, Zip		
Employer		
Receive Separate Mailings? Yes / No	Legal Guardian? Yes / No	Custodial Parent/Guardian? Yes / No
Other Legal Guardian		
Name	Relationship	
Home Phone		
Work Phone		
Cell Phone		
Email		
Mailing Address/PO Box		
Mailing City, State, Zip		
Employer		
Receive Separate Mailings? Yes / No	Legal Guardian? Yes / No	Custodial Parent/Guardian? Yes / No

Certificate of Truthfulness - I certify that all statements on this student registration form are made truthfully and without evasion, and further understand and agree that such statements may be investigated and if found to be false, will be sufficient reason for possible removal of this student from enrollment in the Jackson Public School District and may result in possible legal action.

_____ _____

Parent / Legal Guardian Signature Date

Jackson Public Schools
Emergency Contact / Permission Form

Emergency Contact Form

Student Name: _____

The emergency contacts you supply in this section are the people/numbers that will be called after we have tried to contact the contacts listed on the Registration Form. By providing their information here, it is assumed that you are authorizing these contacts to pick up your child from school in the event of an emergency. These contacts will only be called for emergencies involving your child as an individual or should conditions arise which make it necessary for early dismissal. Otherwise **a note must be provided by a parent or legal guardian for anyone to pick your child up from school.**

Emergency Contact 1 (required)	
Name	Relationship
Home Phone	
Work Phone	
Cell Phone	

Emergency Contact 2 (required)	
Name	Relationship
Home Phone	
Work Phone	
Cell Phone	

Emergency Contact 3 (optional)	
Name	Relationship
Home Phone	
Work Phone	
Cell Phone	

Jackson Public Schools
Emergency Contact / Permission Form

Permission Form

Student Name: _____

Accident/Serious Illness - In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I heareby authorize the school to call 911 and to follow their instructions.

YES_____ NO_____

Photo Permission - I give permission for my child's picture and writings to be published on the Jackson Public Schools webpage, mLive, and other social media as appropriate.

YES_____ NO_____

Field Trip Permission - I understand that transportation to and from field trip activities will be by school bus or other school sanctioned vehicle, and that my automobile insurance is the primary carrier under Michigan No-Fault Insurance, and I will not hold Jackson Public Schools, the Board of Education or employees liable in case of accident, injury or other mishaps. All trips will be chaperoned by school employees.

YES_____ NO_____

Parent/Student Handbook - I verify that I have read, or will read and familiarize myself with the Parent/Student Handbook.

YES_____ NO_____

Technology Acceptable Use Agreement and Social Media Policy and Guidelines - I have read, or will read and familiarize myself with the Student Education Technology Acceptable Use and Safety and the Social Media Guidelines (found at www.jpsk12.org) and agree to adhere to the privileges, responsibilities and consequences as outlined. Hard copies are available upon request.

YES_____ NO_____

Disclosure of Immunization Information - I authorize Jackson Public Schools to release my child's immunization record and personally identifiable information to the Michigan Department of Health and Human Services and local health department.

YES_____ NO_____

_____ _____

Date Parent/Legal Guardian Signature

RESIDENCY VERIFICATION

According to State Attorney General Opinion No. 5925, school districts have the right to request proof of pupil residency. By signing this affidavit, you are affirming that the address given on all enrollment forms is the legal residence of the parent or guardian enrolling the student and is the residence of the student. If you are living in the home of another person without a rental or lease agreement, that person must sign this document and prove their residency. Post office boxes are not accepted as a valid mailing address.

_____

Student Name(s) Date

_____

Parent/Guardian Signature Date

_____

Signature of Person With Whom Student is Residing (if applicable) Date

_____

Street Address

_____

City/State/Zip

****

Required Forms for Residency Verification:

_____ A valid Driver's License or State ID with current address

If the address given to the school on the enrollment form does not match what is on the ID provided then an additional form from the list below is required (check one)

_____ Purchase or Rental Lease Agreement

_____ Voter Registration Card with current address

_____ Property Tax Statement (current)

_____ Current Utility Bill (last 30 days)

_____ Insurance form with current address

_____ DHHS document with name and address

****

If you are NOT a resident of the JACKSON PUBLIC SCHOOLS district, you will need to complete the parent sections of the School of Choice form which will accompany the District Release Letter before enrollment can take place.

****

FOR SCHOOL STAFF USE ONLY

Signature of Staff Person Enrolling Student _____

Date _____

Revised January 30, 2026

VISION – HEARING – DENTAL SCREENING

The State of Michigan requires that your child receive hearing, vision and dental screening before they enter school for the first time.

For additional information, contact:

- Jackson County Health Department: 517-788-4420
- Center for Family Health: 517-748-5500
- Your healthcare provider

Child's Name: _____

	Date of screening	Location of Screening
Hearing		
Vision		
Dental		

Revised 1/28/2021

JACKSON PUBLIC SCHOOLS
McKinney-Vento Homeless
Form Revised 1/30/2026

This form is intended to address the ***McKinney-Vento Homeless Assistance Act*** under the guidelines of the Every Student Succeeds Act (ESSA), 2015. Your answers will help the administrator determine the supplemental needs of the student. (**Complete one form per student).**

1. Presently, where is the student living?

Section A (Living Arrangements) – check one box	Section B (Student's Supplemental Needs)
☐ in a shelter/transitional housing ☐ temporarily, with more than one family in a house or apartment due to economic hardship or loss of housing ☐ in a motel/hotel, car or campsite ☐ unsheltered (on the street, car, park or abandoned building) ***CONTINUE***: *If you checked a box in **Section A**, complete **Section B** and the remainder of this form.* ***STOP:*** If you **did not** check a box in this section, you **do not** need to complete this form.	☐ Transportation to and from school ☐ Tutoring ☐ Personal Hygiene Items ☐ Clothing ☐ Counseling Other: _____

2. The student lives with:

☐ 1 parent
☐ 2 parents
☐ 1 parent & another adult
☐ a relative, friend(s) or other adult(s)
☐ alone with no adults (Unaccompanied Youth)
☐ an adult that is not the parent or the legal guardian

School _____

Student's Name _____ Male ☐ Female ☐

Date of Birth _____/_____/_____ Age ____ Grade _____ Ethnicity _____

Name of Parent/Legal Guardian _____ Phone _____

Address _____

Signature of Parent/Legal Guardian _____ Date _____

For any choices selected in **Section A**, this form must be completed and emailed to **JPS Homeless Liaison (Mrs. Kelly Crum)** immediately after completion. Original forms are kept (in the school) separate from the student's CA-60 for audit purposes during the school year.

Email: Kelly.Crum@jpsk12.org Date emailed: _____

Name and phone number of a school contact person who may know of the family's situation:

Name _____ Phone _____

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McKinney-Vento Clothing and Personal Hygiene Order Form

Name		Gender	
Parent/Guardian		Phone #	
MV Reason		Teacher/Grade	

Clothes	Size	Notes
Shirts		
Pants		
Shorts		
Sweatshirt/Hoodie		
Shoes		
Socks		
Underwear		
Bra		
Pajamas		
Outerwear	**Size**	**Notes**
Winter Coat		
Snow Pants		
Boots		
Hats & Gloves		

Personal Care			
Shampoo/Conditioner		Hair Brush	
Soap	Bar or Wash	Hair Ties	
Deodorant		Laundry Soap	
Toothpaste		Feminine Hygiene	
Toothbrush		Other	

Favorite Colors	Other Notes	Delivery or Pick-up

JACKSON PUBLIC SCHOOLS
MICHIGAN DEPARTMENT OF EDUCATION

HOME LANGUAGE SURVEY

Michigan welcomes families of all language backgrounds. Speaking more than one language is a valuable asset!

Please answer the two questions below. If your response to either question is a language other than English, the school district will give an assessment to see if your student may benefit from English language support.

1. **What language is used most at home?** _____

2. **What language is used most by the student?** _____

TITLE III IMMIGRANT FUNDING IDENTIFICATION QUESTION

Was the student born outside of the US or Puerto Rico? _____ Yes _____ No

If yes, when did the student enter the US Schools? _____

Full name of student _____ Gender_____ DOB _____

School Building _____ Grade _____

Teacher's Name (**School Office Use Only**)_____

_____

Signature of Parent/Guardian Address City State Zip

_____

Telephone where you can be reached Date

NOTE: Translated versions of this form are available by contacting the JPS Curriculum Office at 517-841-2147.

Please return this form to your school office.

SCHOOL OFFICE USE ONLY: If Question 1 or Question 2 is anything other than English, this completed form must be faxed immediately to the attention of the EL Coordinator at 517-768-5918. The original form is to be kept at the school in the student's CA-60 for audit purposes during the school year.

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Revised January 30, 2026

Educational Material for Parents and Students (Content Meets MDCH Requirements)

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

UNDERSTANDING CONCUSSION

Some Common Symptoms

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

WHAT IS A CONCUSSION?

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

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

IF YOU SUSPECT A CONCUSSION

1. **SEEK MEDICAL ATTENTION RIGHT AWAY** – A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.

2. **KEEP YOUR STUDENT OUT OF PLAY** – Concussions take time to heal. Don't let the student return to play the day of injury and until a health care professional says it's OK. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Repeat or second concussions can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. It is better to miss one game than the whole season.

3. **TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION** - Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior or personality changes

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

HOW TO RESPOND TO A REPORT OF A CONCUSSION

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rest breaks, be given extra help and time, spend less time reading, writing or on a computer.

Parents and Students Must Sign and Return the Educational Material Acknowledgement Form

CONCUSSION AWARENESS
EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and/or the Concussion Fact Sheet for Athletes provided by Jackson Public Schools.

Participant Name, Printed	Parent/Guardian Name, Printed
Participant Name, Signature	Parent/Guardian Name, Signature
Date	Date

Return this signed form to the school office. It must be kept on file for the duration of participation or age 18.

Participants and parents please review and keep the educational materials available for future reference.

Jackson Public Schools Device Contract

Student Name _____ **Grade** _____

Parent/Guardian Name _____

By signing below, we understand that:

- All technology distributed to me or my child is property of Jackson Public Schools (JPS).
- All technology, including device chargers and provided cases/bags, must be returned in good working condition within 5 business days of completion or termination from the program.
- Any programs or websites that are not related to JPS curriculum are prohibited on JPS devices.
- We are responsible for any damages to JPS technology equipment that is not normal wear and tear and not covered by any applicable purchased insurance plan.
- JPS requires parent/guardian to purchase insurance after the first device breakage occurs. First repair occurrences for Chromebooks are $15 for repairable damage and $75 for broken beyond repair. First repair occurrences for iPads are $25 for repairable damage and $95 for broken beyond repair. Failure to enroll in this plan will result in their student losing device assignment privileges.
- Device insurance and protection plans are available for all parent/guardians of students, please visit JPSk12.org for more information.
- We are responsible for the cost of replacement of JPS technology if equipment is lost, damaged intentionally or not returned within 5 business days of completion or termination from the program.
- We agree to be responsible digital citizens. I, or my child, will not submit, publish, display or retrieve any defamatory, obscene, racially offensive or illegal material.
- We will not participate in cyber bullying and will report any instances of cyber bullying to JPS representatives.

We acknowledge that we have reviewed this agreement together and understand our responsibilities.

Student _____ Date _____

Parent/Guardian _____ Date _____

****

This section completed by Jackson Public Schools

JPS Representative_____ Date equipment issued _____

Device issued _____ Serial Number _____

Revised 9/04/2024

Grade: _____

Student Technology Use Agreement

Student Name _____ **Parent/Guardian 1** _____
(please PRINT clearly) **(please PRINT clearly)**

School Building _____ **Parent/Guardian 2** _____
(please PRINT clearly) **(please PRINT clearly)**

I have read and understand Board Policy 7540.03 Student Education Technology Acceptable Use and Safety and the Social Media Policy and Guidelines. Both documents are available on the JPS website: www.jpsk12.org. I understand that a failure to follow these policies may result in consequences stated in these rules and our Student Handbook. I understand that the permission granted by this document will be in effect during all school years the student is enrolled at Jackson Public Schools. Any changes to the permission granted by this document must be provided in writing by the parent or JPS.

The following is a summary of the Technology Use and Safety Rules. All students and parents must sign the contract before using District Technology.

- Use of District Technology must be in support of education.
- Users have the privilege to use all of the technology for which they have had training. Anyone using the technology is responsible for the preservation and care of that technology.
- Accounts are to be used only by the owner. The sharing of passwords is prohibited.
- Real names must be used; no aliases are allowed. Additional personal information must not be shared over the Internet.
- Users experiencing harassment or receiving requests for personal information must report the problem.
- Any violations of the use of the technology should be reported to the teacher in charge.
- The district operates virtual education programming. This document authorizes the opportunity for students to take virtual courses when enrolled at JPS.

Please note:

- Internet history and usage will be monitored.
- Technology will not be used for "cyberbullying".
- Copyright laws must be followed.
- Students are not permitted to access any electronic devices used for communication, for capturing images of the test or testing room, or for data storage (e.g., smartphones, smart watches, cell phones, book readers, electronic tablets, pagers, cameras, non-approved calculators, music players, voice recorders, etc.) that can disrupt the testing environment, or be used to compromise the validity, security, and confidentiality of the test. At a minimum, these devices must be powered off and stored away from the students' work area at all times during a test session. These devices cannot be used as a substitute for a calculator. Specific calculator policies are covered in the Test Administrator Manuals particular to each assessment. If a student accesses any of these devices during testing, this will constitute a prohibited behavior and the student's test results in that content area will be invalidated.

The parent/guardian grants permission to publish documents on the World Wide Web. In the event that the parent/ guardian does not grant permission to publish documents, written notice must be submitted to the building/district office.

The student and the parent have access to the Policies and agree to their terms for the duration of the student's enrollment at Jackson Public Schools.

Students violating the Board Policy may be subject to discipline as outlined in the Student Handbook. They may also be subject to legal action if appropriate.

_____ _____
Student Signature/Date Parent 1 Signature/Date

_____ _____
Received By - Signature/Date Parent 2 Signature/Date

JACKSON PUBLIC SCHOOLS
STUDENT HEALTH
INFORMATION 2026-27

School_____ ___Male_____Female

Name_____Birth date___/___/___Grade_____
Last First Middle

Address_____Phone_____
Street City Zip

Race __Native American __Hispanic __Asian American __Caucasian (white) __African American____Other

Doctor's Name_____Date of last physical _____

Dentist's Name_____Date of last exam _____

Does student have any of the following? (please check each listing)

Allergies	___Yes	___No	To medication, food, pollen etc? List_____ Requires Epi-Pen? ___Yes ___No Requires Emergency treatment? ___Yes ___No
Asthma	___Yes	___No	Diagnosed by doctor? ___Yes ___No Does student need to use inhaler at school? ___Yes ___No Requires emergency treatment? ___Yes ___No
Bee Sting Allergy	___Yes	___No	Diagnosed by doctor? ___Yes ___No Requires Epi-Pen? ___Yes ___No Reaction: Difficult breathing ___Yes ___No Local Swelling ___Yes ___No Requires Emergency treatment? ___Yes ___No
Diabetes	___Yes	___No	Takes insulin? ___Yes ___No Comments _____
Epilepsy/ Seizures	___Yes	___No	Medication_____Date of Last Seizure _____
Heart Condition	___Yes	___No	Diagnosed by Doctor ___Yes ___No Medication_____ Physical restrictions? ___Yes ___No Comments_____ _____

List medical information, such as any serious illnesses, surgeries or injuries in the past 12 months _____

_____

What **medications** are regularly taken_____dose_____purpose _____
_____dose_____purpose_____

In order to assure that your child is cared for appropriately, information that might affect your child's safety and well being may be shared with appropriate school personnel.

CONSENT FOR TREATMENT

SCHOOL HEALTH PROGRAM FOR 2026-27 SCHOOL YEAR

* *

Dear Parent/Guardian:

School personnel manages medication distribution. Further, distribution will be limited to prescription medications only.

Procedurally, the parent/guardian must:

1) Bring the prescribed medication in, with it being in the original and labeled container;
2) Medications will be accounted for and signed with the parent present;
3) Medication form must be completed by parent and physician;
4) Parent/guardian is responsible for knowing the needed time for refill.

I give my permission for (**child's name**) ____
to receive basic health care treatment, health education and emergency care by school personnel.

Parent/Guardian____________________________________Date______/_____/_____

This consent will be in effect for the current school year

* *

PLEASE PRINT:

Parent 1/Guardian____________________________________Home Phone _______________
Work Phone ________________
Cell Phone _________________

Parent 2/Guardian____________________________________Home Phone _______________
Work Phone ________________
Cell Phone _________________

Emergency Contact___________________________________Home Phone _______________
Relationship to Student________________________________Work Phone ________________
Cell Phone _________________

Emergency Contact___________________________________Home Phone _______________
Relationship to Student________________________________Work Phone ________________
Cell Phone _________________

The next three forms are for Young 5's / Kindergarten Students Only

Jackson $aves
CHILDREN'S SAVINGS ACCOUNT

Student Enrollment Form

www.jacksonsaves.org

Student Information (REQUIRED)	School
First Name	Middle Name
Last Name	Birth Month/Day/Year

What Is Jackson Saves?

The Jackson Saves Program provides local kindergarteners with a savings account funded with an initial deposit of $50.00*, and is designed to help students save money to pay for their college or career training expenses after high school. Jackson Saves is a savings program brought to you by the Jackson Community Foundation, TRUE Community Credit Union, the Jackson County Intermediate School District and your school. For more information, visit *www.jacksonsaves.org.*

☐ YES! I want my child to begin saving for their future with Jackson Saves!

I understand that the following information is needed to participate in the Jackson Saves Program:

- Student's Full Name
- Birth Date
- Mailing Address (including city and zip code)
- School Building
- District Name
- Grade Level
- UIC Code (state assigned unique student number)

I understand that the Family Educational Rights and Privacy Act (FERPA), a federal law, allows my student's school district to disclose designated "directory information" about my student to third parties without my consent, unless I tell them not to do so, in writing. The law also says that I can give permission to my student's district to share additional information about my student, such as birth date and student UIC code, by providing written consent. By signing below I am authorizing my student's school/district to share the above stated information with the Jackson Community Foundation and TRUE Community Credit Union in order to start my Jackson Saves Program account, receive and track additional donations, and otherwise administer my student's account information. I am further authorizing my student's school to work with the Jackson County Intermediate School District to facilitate my student's participation in the Jackson Saves Program.

Printed Parent/Guardian Name

X

Parent/Guardian Signature

Date

☐ **Please add me as a contact record on my child's account.**

Home Address

Phone

Email Address

☐ No, thank you. I would like to OPT OUT.

I have "opted out" of the Jackson Saves Program for my student, I understand that my student's school will not share the information needed to enroll my student in the Jackson Saves Program with the Jackson Community Foundation and/or TRUE Community Credit Union. I understand my student will not be part of this Program and that I ***will not be able to enroll them at a later date.***

Printed Parent/Guardian Name

X

Parent/Guardian Signature

Date

Financial Institution Disclosure

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person on an account. For this reason, we will need your child's full name, address, date of birth, and other information that will allow us to identify your child.

This is a deposit-only account. Withdrawals are prohibited until the student meets eligibility requirements. Accounts will be opened in January for all students enrolled by September 30 of their initial kindergarten enrollment year.

*Subject to the availability of program funds.

Revised 10/20

Federally Insured by NCUA

Prior Care Consent Form for 2026-2027 Incoming Kindergarteners

Permission for the release of information

I, _____, give permission for my child's preschool/childcare program to share information with representatives of _____, the school I am interested in enrolling my child in for Kindergarten. This information will include but not be limited to educational records, reports and evaluations that have been generated regarding my child.

Child's Name: _____ **D.O.B**._____

My child attended:

___ GSRP ___ Head Start ___ Child Care - Home Based ___ Child Care - Center ___ Tuition PreK

___ Home ___ Young 5's / Developmental Kindergarten ___ Family/Relative ___ Special Education Classroom

ABC Academy:
Contact: Katie Clough
734-726-0395
katlync@abcacademyjackson.com

___ Lansing Ave

___ Laurence Ave

___ Jackson College

___ Hunt Elementary

___ John R. Lewis Elementary

___ Concord Elementary
Contact: Kim Brooks
517-524-6650
kim.brooks@concordschools.net

Early Impressions:
Contact: Jessica Crupi
517-247-8410
jc.earlyimpressions@gmail.com

___ E. Michigan Ave

___ Hanover-Horton Elementary

___ Keicher Elementary (MC)

___ Northwest Preschool

___ Springport Elementary

___ Townsend Elementary (VCL)

___ Woodville Center

___ JCISD Central Campus
Contact: Jodi Collins
517-867-5900
jodi.collins@jcisd.org

Phoenix Early Learning Cntr:
Contact: Andrea McCabe
517-513-8048
amccabephoenix@gmail.com

___ Kibby Road

___ Prospect Road

___ East Jackson Elementary

___ Murphy Drive

___ N. Dettman Road

___ Columbia Elementary
Contact: Terri McLaury 517-592-9753
terri.mclaury@myeagles.org

___ daVinci Elementary
Contact: Kristi Nodine 517-780-9980
kristi.nodine@davincik12.org

___ Grass Lake - Little Warriors
Contact: Christie Orban 517-867-5650
christie.orban@grasslakeschools.com

___ Napoleon - Pirate's Cove
Contact: Jennifer Snyder 517-905-5701
jennifer.snyder@napoleonschools.org

___ Lil' Beginners - Napoleon
Contact: Alexis Hayes
517-536-7144
lilbeginnerslc@gmail.com

Community Action Agency:
Contact: Codi Benjamin
517-784-4800
cbenjamin@caajlh.org

___ Ashton Ridge

___ Chalet Terrace

___ Cascades Elementary

___ Dibble Elementary

___ Hunt Elementary

___ JCISD Central Campus

___ John R Lewis

___ Northeast Elementary

___ Northwest Preschool

___ St John's UCC

___ Salvation Army

___ Shahan

___ Springport Elementary

___ Torrent Center

___ Townsend Elementary (VCL)

___ Other

___ Felician Children's Center
Contact: Tracy Smith-Jackson
517-841-3876
tjackson@feliciansisters.org

___ Countryside Montessori
Contact: Lindsey Bramlet
517-529-7016
lindsey.cmspreschool@gmail.com

_____ _____

SIGNATURE OF PARENT / GUARDIAN **DATE**

OFFICE USE ONLY:

UIC: _____ Placement: _____

MDHHS-6067, KINDERGARTEN ORAL HEALTH ASSESSMENT

Michigan Department of Health and Human Services (MDHHS)
(New 8-23)

SECTION 1 – STUDENT INFORMATION

Child's Name (Last, First, Middle)	Date of Birth
Address (Number, Street, City, Zip Code)	Home/Cell Phone Number
Parent/Guardian Name (Last, First, Middle)	Parent/Guardian Email
School Name	

SECTION 2 – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS
(Licensed dental professional must complete this section)

Date of Service	Type of Service ☐ Dental Exam ☐ Dental Assessment
Findings (Check all that apply) ☐ No findings ☐ Treated decay ☐ Untreated decay	Recommendations (Check **one**) ☐ Routine care ☐ Referral for dental treatment ☐ Referral for urgent dental care
Provider Type (Check **one**) ☐ Dentist	☐ Dental Therapist ☐ Dental Hygienist
Provider Signature	Agency/Local Health Department
Provider Name (Print)	Phone Number
Additional Comments	

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