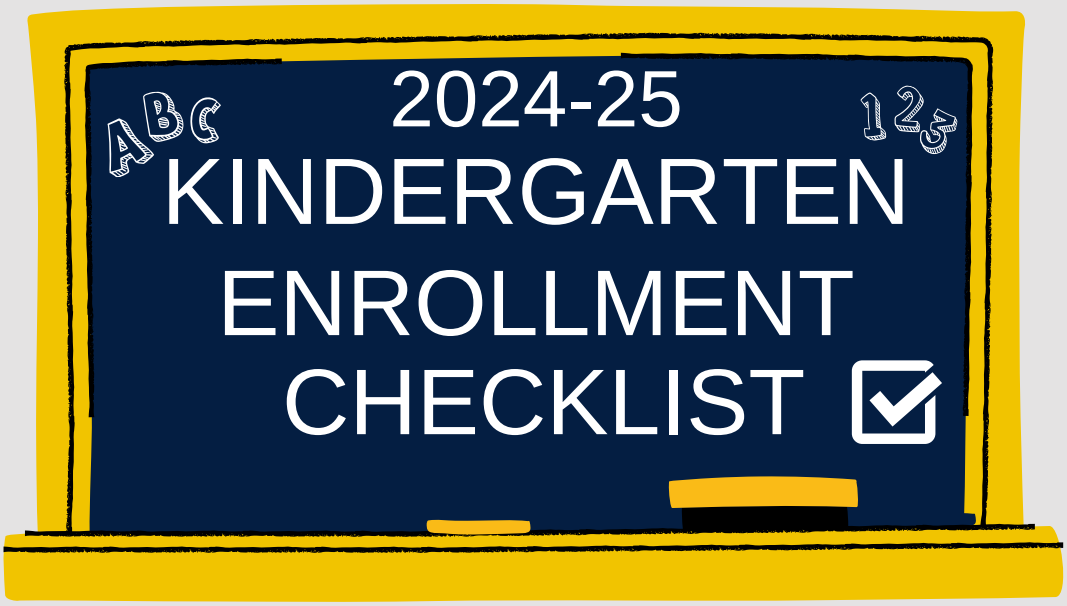
OVID-ELSIE AREA SCHOOLS



We can not accept any enrollment without the following:

- ☐ Completed and signed enrollment packet.
- ☐ A certified copy of the **legal birth certificate** (available from the county clerk where the child was born or the State Health Department).
- ☐ Your child's **STATE OF MICHIGAN immunization record. SIGNED BY YOUR DOCTOR OR NURSE**.
- ☐ **Proof of residency.** A bill that has your address on: (Consumers, telephone, etc.)
- ☐ A **Completed Physical Health Form, Dental & Eye Exam,** is required for each student prior to the school start date.
- ☐ Health Intake Form Completed www.ovidelsie.org/oeashealthform
- ☐ Drivers Licence or ID of parent/guardian

Please check the front and back of all forms to ensure they are filled out correctly and return them with all additional requested documents by email. You can also, drop it off or mail it to Leonard Elementary or District Administration Office.

**Please keep in mind that submitting the registration form does not guarantee your child a spot at Leonard Elementary. Once all documentation is completed a placement determination will be made.

Leonard Elementary | Ph: 989-834-5029 | 732 N. Mabbitt St. Ovid | Email: Leonard@ovidelsie.org

Ovid-Elsie Area Schools Student Registration Form

Today's Date _____ Re-enrolling in Ovid-Elsie Area Schools Yes ___ No ___ Start Date _____

STUDENT INFORMATION

Student Legal Name: _____ Gender: M___ F___ Grade: ____
Last First Middle Suffix

Preferred/Nick Name_____ Birth date:__/____/____ State/Country of Birth: _____

Ethnicity: Is this student Hispanic/Latino? Yes ___ No___
(A person of Cuban, Mexican, Puerto Rican, South or Central American or Spanish culture or origin, regardless of race)

Race: (Please check all that apply) ___ White ___ Hispanic/Latino ___ Black/African American ___ American Indian/Alaskan Native ___ Asian ___ Native Hawaiian/Pacific Islander

Note: Both Ethnicity and Race sections must be completed. We encourage you to select an answer for both parts. ***If either part is not answered, the US Department of Education requires the school district to supply an answer on your behalf.***

ADDITIONAL STUDENT INFORMATION

Do you live in the Ovid-Elsie Area School District? Yes___ No___ If No, what school district do you reside?_____

Have you or a family member worked in agriculture, poultry or dairy in the past 3 years? If yes, where? _____

If your child/student was born outside of the U.S., when did the child/student enter the U.S.? _____

Does the child currently have a parent who is a member of the Armed Forces on active duty (does not include the National Guard)?
Please specify: Which parent: _____ Branch of the Military: _____

Name of the last school attended: _____

Has your child ever been suspended or expelled? Yes ___ No___ **If yes,** from where? _____
Please explain: _____.

STUDENT PRIMARY ADDRESS INFORMATION

Address:_____
Number N/S/E/W Street Name City State Zip Apt/Lot# PO Box

Household Phone: (_____) _____ County: _____

Student is living with: ___Mother ___Father ___Stepmother ___Stepfather ___Host Family ___Foster-Parent ___Guardian ___Other

PARENT/LEGAL GUARDIAN INFORMATION (As it appears on Birth Certificate or Legal Documentation)

LAST Name: _____ FIRST Name: _____

MIDDLE NAM___ Gender: M___ F___
Marital Status: ___ Single ___ Married ___ Divorced

Address if different than student's address:

_____
Street

_____
City State Zip

Cell # : _____ Daytime #:: _____

Email address: _____

Relationship to student: __ Parent __ Foster __ Court placed
Other: _____

Custody of Student: ___Legal ___Physical ___Joint

LAST Name: _____ FIRST Name: _____

MIDDLE NAM___ Gender: M___ F___
Marital Status: ___ Single ___ Married ___ Divorced

Address if different than student's address:

_____
Street

_____
City State Zip

Cell # : _____ Daytime #:: _____

Email address: _____

Relationship to student: __ Parent __ Foster __ Court placed
Other: _____

Custody of Student: ___Legal ___Physical ___Joint

(OVER)

PLEASE LIST OTHER CHILDREN IN YOUR HOUSEHOLD (OLDEST TO YOUNGEST)

First & Last Name	Gender	Birthdate	Relationship	Grade

RESIDENCY VERIFICATION

☐ **Own a home** ☐ **Rent/Lease** ☐ **Family shares with relative/friends** ☐ **Shelter**

HEALTH INFORMATION

Please circle current medical conditions:

Asthma ☐ ADD/ADHD ☐ Bee Stings ☐ Diabetes ☐ Drug Allergy ☐ EPI-pen ☐ Food Allergy ☐ Seizure ☐

Other:_____ Other:_____

If Drug and/or Food allergy is circled, specify what this student is allergic to:_____

Please list prescribed medications currently taken by this student: _____

Please note: All medications taken at school must follow Michigan Law, which requires schools to have a written physician's order and parent/guardian authorization. (Medication Authorization forms available online or at the school)

SPECIAL NEEDS INFORMATION

Special program(s) received at prior school:

☐ Special Education ☐ Speech ☐ ESL ☐ Reading ☐ Social Work ☐ Other - please describe:_____

EMERGENCY CONTACT INFORMATION

Household Emergency Contact Information (Parents/Step-parents/Guardians)
Number from 1 to 4 the order these should be contacted (if applicable):

____Mother ____Father _____Stepmother ____Stepfather ____Other: _____ Other: _____
Name Name

Non-Household Emergency Contact Information (if case Parent/Guardian is not available)

1. Name: _____ Gender: M ☐ F ☐
Last First Middle Suffix
Relationship to student: _____ Cell:_____Home: _____Work: _____

2. Name: _____ Gender: M ☐ F ☐
Last First Middle Suffix
Relationship to student: _____ Cell:_____Home: _____Work: _____

EMERGENCY CARE PERMISSION

As the parent/guardian, my signature affirms that information provided within this form is true and accurate, and that my child and I reside at the stated address. I understand false information provided by me may be subject to legal penalties for perjury.

In case of serious illness or injury, I hereby request and give my full consent for authorized school personnel to transport my child directly to the nearest hospital, or send by ambulance if needed, and I will assume all financial obligations. I further authorize any licensed physician or dentist and/or hospital to provide necessary treatment. I understand this health information can be shared when it is educationally relevant for academic progress, necessary for providing health services including emergency care, or essential to ensure the protection of other students and school personnel. I understand this permission will continue to be in effect as long as the student is enrolled in Ovid-Elsie Area Schools, unless revoked in writing.

Signature of Parent/Guardian:_____ Date:_____

Ovid-Elsie Area Schools

Health History and Intake Form

Providing the following health and healthcare needs and information will assist the school nurse in providing a safe school environment for your student. The information is **CONFIDENTIAL** and will be shared **only** with the school staff who need to know (e.g., school nurse, principal, school health team).

You are able to electronically fill out this form by completing on-line at https://www.ovidelsie.org/healthform

STUDENT INFORMATION

Student Name (First Last): _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Grade: _____

Primary Physician/Healthcare Provider _____

Preferred Hospital _____

HEALTH INSURANCE

My student is covered by ☐ Public (Medicaid/Medicare) ☐ Private (BCBS/Aetna, etc.) ☐ No Insurance

Are you interested in receiving information about low-income eligible, health insurance programs in Michigan? ☐ Yes ☐ No

CHRONIC DISEASE ASSESSMENT

Is the student currently under treatment for any of the following:

Asthma: ☐ Yes If yes please provide a copy of the Asthma Action plan ☐ No

Allergies to ☐ Food ☐ Insects ☐ Medication ☐ Latex ☐ Unknown

List name of allergens: _____

Any Food Intolerance or Celiac Disease ☐ Yes ☐ No

If yes please specify: _____

History or risk of Anaphylaxis: ☐ Yes ☐ No

*If yes please provide a copy of the EmergencyAllergy Action plan

Diabetes ☐ Type 1 ☐ Type 2 ☐ N/A

*If either Type please provide a copy of the Diabetes Medical Management Action plan

Seizures ☐ Yes ☐ No

*If yes please provide a copy of the Seizures Action plan

List Type and Frequency of Seizure Activity _____

CHRONIC DISEASE ASSESSMENT

Indicate other health conditions for your student by checking the boxes below and providing comments

Condition	Condition	Condition	Condition
☐ Anxiety/Emotional concerns	☐ Bleeding Problem or Frequent Nosebleeds	☐ Head Injury such as History of Concussions	☐ Scoliosis
☐ Arthritis	☐ Bowel Problem or Frequent Stomachaches or Constipation or Indigestion or Feeding Tube	☐ Headaches/Frequent or Migraine	☐ Sickle Cell Disease
☐ Attention Deficit/Hyperactivity Disorder	☐ Cerebral Palsy	☐ Hearing Concerns or Frequent Ear Infections or Deafness - Indicate if Wears Hearing Aid or Cochlear Implant	☐ Social Concerns (recent change in family such as divorce, death of family member)
☐ Autism	☐ Cystic Fibrosis	☐ Heart problems or Blood Pressure Concerns	☐ Speech concerns
☐ Behavioral Concerns	☐ Dental Problems	☐ Hospitalizations and Surgeries	☐ Spinal Injury or Spina Bifida
☐ Breathing Problem or Tracheotomy or Requires Oxygen	☐ Depression, Self-harm, or Suicide Concerns	☐ Intellectual Disability	☐ Underweight or Overweight
☐ Developmental Concerns	☐ Eating Disorder	☐ Lead Poisoning	☐ Vision Deficits/Wears Glasses or Contacts/Color/Low Vision or Blindness
☐ Bladder Problem or Kidney Disease	☐ Feeding or Swallowing Concern	☐ Muscle Problems/Mobility or Physical Activity Restrictions	☐ Other Conditions: (Please provide a list in the comment section below)

Comments:

☐ My Student **does not** have any of the above conditions

MEDICATION

Does your student take any medication routinely at home or at school? If yes Please complete the information below.	☐ Yes	☐ No

Name of Medication	Time(s) Given	Will it be taken at school?	Purpose
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

PARENTAL CONSENT

Would you like to schedule a conference with the licensed school nurse to discuss a particular health concern? Indicate your concern(s):	

The information you provide will only be shared with school staff who require access to this information to meet your child's health and safety needs while at school. Not providing complete and accurate information may result in an incomplete health and safety plan for your child.

Parent/Guardian Name Printed	**Parent/Guardian Name Signature**	**Date**

HEALTH APPRAISAL

Michigan Department of Health and Human Services

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual, and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse, dentist, dental therapist, and dental hygienist.
(**BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION**).

PERSONAL

Child's Name (Last, First, Middle)	Date of Birth (mm/dd/yy)
Address (Number, Street, City, Zip Code)	Today's Date (mm/dd/yy)
Parent/Guardian (Last, First, Middle)	Home/Cell Phone Number
Address (Number, Street, City, Zip Code)	Work Phone Number

SECTION I – HEALTH HISTORY

Yes	No	Resolved	#	Is your child having any of the problems listed below?
☐	☐	☐	1	Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2	Anaphylaxis
☐	☐	☐	3	Does your child take any medication(s) regularly?
☐	☐	☐	4	Hay Fever, Asthma, or Wheezing
☐	☐	☐	5	Eczema or Frequent Skin Rashes
☐	☐	☐	6	Convulsions/Seizures
☐	☐	☐	7	Heart Trouble
☐	☐	☐	8	Diabetes
☐	☐	☐	9	Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	10	Trouble with Passing Urine or Bowel Movements
☐	☐	☐	11	Shortness of Breath
☐	☐	☐	12	Speech Problems
☐	☐	☐	13	Menstrual Problems
☐	☐	☐	14	Dental Problems Date of Last Exam_____ **OR** Date of Last Assessment_____
☐	☐	☐		Other (please describe)_____

Birth History
If yes, list medications
Are there any current or past diagnosis(es) ☐ Yes ☐ No
If yes, please describe

Reason for Medication		
Concussion History		
Parent/Guardian Signature	Date	Was the health history reviewed by a health professional? ☐ Yes ☐ No **Examiner's Initials** ____

SECTION II – PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS
Required for Child Care and Head Start / Early Head Start

Test and Measurements

Yes	No	Was child tested for	Tests and results	Normal	Referred	Under care
☐	☐	Vision Date _____	Visual Acuity	☐	☐	☐
				☐	☐	☐
			Muscle Imbalance	☐	☐	☐
☐	☐	Hearing Date _____	Other			☐
			☐ Audiometer (R= Right, L=Left)	R/L	R/L	☐
			☐ OAE (R= Right, L=Left)	R/L	R/L	☐
☐	☐	Urinalysis	Other (R= Right, L=Left)	R/L	R/L	☐
			Sugar	☐	☐	☐
			Albumin	☐	☐	☐
☐	☐	Blood Lead Level Date _____	Microscopic Level_____ug/dl	☐	☐	☐

Note: All children in Medicaid need to be tested at 1 and 2 years of age, or once between 3 and 6 years of age if not previously tested. All children, regardless of Medicaid status, should be tested at those same ages if they live in an area where lead risk is high.

☐	☐	Height & Weight ⇨		☐	☐	☐
			Height	☐	☐	☐
			Weight	☐	☐	☐
☐	☐	Other_____	Other_____	☐	☐	☐
☐	☐	Hemoglobin/Hematocrit		☐	☐	☐
		Blood Pressure	Reading_____			

Complete pediatric tuberculosis risk assessment available at:
https://www.michigan.gov/documents/mdhhs/4._MI_Pediatric_TB_Risk_Assessment_661537_7.pdf **OR**
feel free to use the attached QR code instead of the full link text.

Examinations and/or Inspections

Essential Findings Deviating from Normal
Exam Date _____

SECTION III – IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied based on this information.*****

Vaccines (Circle Type)	Date Administered		Vaccines (Circle Type)	Date Administered mm/dd/yy	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	3
	2	4		2	
DTaP/DTP/DT/Td	1	4	Influenza (IIV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal MenACWY (MCV4)	1	3
				2	
Tdap	1		Meningococcal B (Bexsero, Trumenba)	1	3
				2	
Haemophilus Influenzae type b (HIB)	1	3	Human Papillomavirus (9vHPV, 4vHPV, 2vHPV)	1	3
				2	
	2	4	Additional Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Polio (IPV/OPV)	1	4		1	
	2	5		2	
	3			3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable.		
	2	4			
Rotavirus (RV1/RV5)	1	3	***Note:** According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious, and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
	2				
Measles, Mumps, Rubella (MMR/MMRV)	1	3			
	2				
Varicella (Chickenpox), (Var, MMRV)	1	2			
History of Chickenpox Disease? ☐ Yes ☐ No If yes, date _____			Parent/Guardian refused recommended immunizations at visit: ☐		
I certify that the immunization dates are true to the best of my knowledge ☐					
Health Professional's Signature		Title		Date	

SECTION IV – RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

Yes	No	
☐	☐	Is there any defect of vision, hearing, or other condition for which the school could help by seating or other actions? If yes, please explain: _____

☐ ☐ Should the child's activity be restricted because of any physical defect or illness?
If yes, check and explain degree of restriction(s):

☐ Classroom ☐ Playground ☐ Gymnasium
☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V – DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS

Child's Name	Type of Service ☐ Dental Exam ☐ Dental Assessment
Findings (check all that apply) ☐ No findings ☐ Treated decay ☐ Untreated decay	Recommendations (check <u>one</u>) ☐ Routine care ☐ Referral for dental treatment ☐ Referral for urgent dental care
Provider Signature	Date
Provider Type (Check **one)** ☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist	

PHYSICIAN'S SIGNATURE

Examiner's Signature	Date	Examiner's Name (Print)		Degree or License
Number & Street	City	MI	Zip Code	Telephone Number

Information required for:

Early On – Hearing and Vision Status; Diagnosis; Health status

Child Care Licensing – Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start – Determination that child is up-to-date on a schedule of age-appropriate preventative and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-childcare visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

OVID-ELSIE AREA SCHOOLS

Students First!

Electronic Device Protection Plan

8989 Colony Road Elsie, MI 48831
(989) 834-2271 www.ovidelsie.org Fax (989) 862-5887

Ovid-Elsie Area Schools (OEAS) is providing and administering an accident protection plan as part of our current digital learning initiative. Enrollment in this plan is required for anyone planning to take a school district electronic device home who has not otherwise provided evidence of coverage that is acceptable to the district and equal to or greater than what is indicated in this agreement. This plan covers "accidental damage" to the electronic device and is designed to limit individual financial responsibility for any damage as described in the coverage section below. Each school year the annual premium begins coverage for all electronic devices provided by the school district for use by individual staff members or students. In addition, each electronic device is covered under a manufacturer's warranty that covers the normal operation of the electronic device to ensure that it is functioning properly.

Program Rate / Coverage

$20 annual premium
$5 copay for 2nd/$10 for 3rd device claim
Full repair cost after third claim
$60 annual maximum/household
Limit of Liability: $245.00 annually for each separate electronic device.

Effective Coverage / Expiration Date

- Effective Date: Based on the receipt of signed agreement
- Expiration Date: Last day of employment/ enrollment for the current school year or one year from the date of the last signed agreement with OEAS.

Coverage

- Accidental Damage: Pays for accidental damage caused by liquid spills, drops, or any other unintentional event.
- Theft: Pays for loss or damage of the electronic device due to theft. The claim requires a police report to be filed.
- Fire: Pays for loss or damage of the electronic device due to fire. The claim must be accompanied by an official fire report from the investigating authority.
- Electrical Surge: Pays for damage to the electronic device due to an electrical surge.
- Natural Disasters: Pays for the loss or damage of the electronic device caused by natural disasters.

Exclusions

- Dishonest, Fraudulent, Intentional, Negligent or Criminal Acts: Will not pay if damage or loss occurs in conjunction with dishonest fraudulent, intentional, negligent or criminal act. Individuals will be responsible for the full amount of the repair/replacement.
- Consumables: Including but not limited to the case ($30,)
- Individuals will be responsible for full cost of repairs after the third claim.
- the charger ($30), and software. Cosmetic Damage that does not affect the functionality of the device. This includes but is not limited to scratches, dents, and broken plastic ports/parts or port covers.
- Voiding the manufacturer's warranty by tampering with the device or system software.
- OEAS is not liable for any loss, damage (including incidental, consequential, or punitive damages) for expenses caused directly or indirectly by the equipment.

PLEASE REVIEW THE INFORMATION, FILL OUT THE BACK SIDE, AND RETURN WITH YOUR PROTECTION FEE.

OVID-ELSIE AREA SCHOOLS

Students First!

Electronic Device Protection Plan

Child's Name		GRADE:
Parent/Guardian Name		Homeroom (K-5):
Mailing Address		First hour (6-8):
City, State, Zip		Advisory (9-12):
Home Phone:	Cell Phone:	

I WILL participate in the Ovid-Elsie Area School District's Electronic Device Accident Protection Plan.

I agree to the provisions outlined in the policy terms and understand that:

- Enrollment in this program is required.
- **A $5.00 copay will be collected for second and $10 for a third claim for device repairs; subsequent repair costs will be the responsibility of the individual in full limited to parts and not including labor.**
- The policy only covers the school issued electronic device and does not cover the charger, case or stickers.
- This policy does not cover cosmetic damage that does not impair the use of the electronic device; including, but not limited to: scratches, dents, and broken plastic parts or connection ports.
- Damage as a result of a violation of the Electronic Device User Agreement is not covered; including, but is not limited to: dishonest, fraudulent, intentional, negligent, or criminal acts.
- Damage to the device is still the responsibility of the individual employee or student.
- Liability is limited to the replacement/repair of the device; no additional liability is implied or assumed.
- Opening the casing of the device to expose its internal components or hacking the operating system voids warranties and is not covered by this policy. Physically tampering with or hacking the operating system in an attempt to modify a device removes manufacturer protections.
- Devices covered by this protection plan must be in an approved case. Damage that occurs in transit to or from the school site or school activities when the device is not housed in an approved case is not covered under this policy.
- Enrollment in this program does not cover: Dishonest, Fraudulent, Intentional, Negligent/Criminal Acts.
- The enrollment cost is non-refundable. If the student leaves the district before January 15 this amount will be prorated.

Student Name: _____ _____

Printed Signature Date

Parent or Guardian Name: _____ _____

Printed Signature Date

Payment Information: (Tech Department use ONLY)

$_____Paid Date:_____ FORM OF PAYMENT: (*circle*) Cash Check #_____

NOTES:

PLEASE REVIEW THE INFORMATION, FILL IT OUT, AND RETURN WITH YOUR PROTECTION FEE.

OVID-ELSIE AREA SCHOOLS

Students First!

Acceptable Use Policy

8989 Colony Road Elsie, MI 48831
(989) 834-2271 www.ovidelsie.org Fax (989) 862-5887

To access and use District Technology Resources (see definition in Bylaw 0100), including a school- assigned e-mail account and/or the Internet at school, students under the age of eighteen (18) must obtain parent permission and sign and return this form. Students eighteen (18) and over may sign their own forms.

Use of District Technology Resources is a privilege, not a right. The Board of Education's Technology Resources, including its computer network, Internet connection and online educational services/apps, are provided for educational purposes only. Unauthorized and inappropriate use will result in loss of this privilege and/or other disciplinary action.

To further review the complete STUDENT TECHNOLOGY ACCEPTABLE USE AND SAFETY AGREEMENT, please go to https://5il.co/7dia

Parent/Guardian

As the parent/guardian of this student, I have read the Student Technology Acceptable Use and Safety Policy and Guidelines, and have discussed them with my child. I understand that student access to the Internet is designed for educational purposes and that the Board has taken available precautions to restrict and/or control student access to material on the internet that is obscene, objectionable, inappropriate and/or harmful to minors. However, I recognize that it is impossible for the Board to restrict access to all objectionable and/or controversial materials that may be found on the internet. I will not hold the Board (or any of its employees, administrators or officers) responsible for materials my child may acquire or come in contact with while on the internet. Additionally, I accept responsibility for communicating to my child guidance concerning his/her acceptable use of the internet - i.e., setting and conveying standards for my daughter/son to follow when selecting, sharing and exploring information and resources on the internet. I further understand that individuals and families may be liable for violations.

To the extent that proprietary rights in the design of a web page, site, service or app hosted on Board-owned or District-affiliated servers would vest in my child upon creation, I agree to assign those rights to the Board.

Student

By signing the attached sheet I have read and agree to abide by the Student Technology Acceptable Use and Safety Policy and Guidelines. I understand that any violation of the terms and conditions set forth in the Policy and Guidelines is inappropriate and may constitute a criminal offense and/or may result in disciplinary action. As a user of District Technology Resources, I agree to communicate over the internet and through the Technology Resources in an appropriate manner, honoring all relevant laws, restrictions and guidelines.

Please follow the link or QR Code to review the entirety of the

Student Technology Handbook including Acceptable Use Policy, Electronic Device Protection Plan

or visit

https://www.ovidelsie.org/page/policies-procedures

PLEASE REVIEW THE INFORMATION, FILL OUT THE BACK SIDE, AND RETURN.

OVID-ELSIE AREA SCHOOLS

Students First!

STUDENT TECHNOLOGY ACCEPTABLE USE AND SAFETY AGREEMENT

Parent/ Guardian

I agree to the provisions outlined in the STUDENT TECHNOLOGY ACCEPTABLE USE AND SAFETY AGREEMENT and:

- As the parent/guardian of this student, I have read and agree to the Student Technology Acceptable Use and Safety Policy and Guidelines, and have discussed them with my child.
- I understand that student access to the Internet is designed for educational purposes and that the Board has taken available precautions to restrict and/or control student access to material on the internet Ovid-Elsie Area Schools Technology Handbook approved 5/17/2015 that is obscene, objectionable, inappropriate and/or harmful to minors. However, I recognize that it is impossible for the Board to restrict access to all objectionable and/or controversial materials that may be found on the internet. I will not hold the Board (or any of its employees, administrators or officers) responsible for materials my child may acquire or come in contact with while on the internet.
- I understand that individuals and families may be liable for violations.
- I accept responsibility for communicating to my child guidance concerning his/her acceptable use of the internet
- I give permission for the Board to issue an e-mail or other appropriate software or internet account to my child.
- I give permission for my child's image (photograph) to be published online, provided only his/her first name is used.
- I give permission for the Board to transmit "live" images of my child (as part of a group) over the internet via a webcam.
- I authorize and license the Board to post my child's class work on the internet without infringing upon any copyright my child may own with respect to such class work.
- I understand only my child's first name will accompany such class work.
- I give permission for my child to take part in virtual courses that the district determines are in the best interest of my student.
- By accepting this district-provided device or service, I confirm that I would otherwise be unable to adequately engage in the education of my students
- I grant permission to my child to obtain a login and password for websites used in the educational process as instructed by teachers for course work. Students may post documents, images and videos to sites such as but not limited to Google Apps, Edmodo, and Moodle as selected by their teacher for teaching and learning.

As the student

- I have read and agree to abide by the Student Technology Acceptable Use and Safety Policy and Guidelines.
- I understand that any violation of the terms and conditions set forth in the Policy and Guidelines is inappropriate and may constitute a criminal offense and/or may result in disciplinary action.
- I agree to communicate over the internet and through the Technology Resources in an appropriate manner, honoring all relevant laws, restrictions and guidelines.

Student Name: _____ _____ _____ _____

Printed (First, Last) Signature Date Grade Teacher

Parent or Guardian Name: _____ _____

Printed Signature Date

McKinney-Vento Information for School-Age Youth and Parents

If you or your family lives in any of the following situations:

- In a shelter
- In a motel or campground due to the lack of an alternative adequate accommodation
- In a car, park, abandoned building, or bus or train station
- **Doubled up with other people due to loss of housing or economic hardship**

You/Your school-age children may qualify for certain rights and protections under the federal Mckinney-Vento Act.

Eligible students have the right to

- Receive a free, appropriate public education.
- Enroll in school immediately, even if lacking documents are normally required for enrollment.
- Enroll in school and attend classes while the school gathers needed documents.
- Enroll in the local school; or continue attending their school of origin (the school they attended when permanently housed or the school in which they *were* last enrolled), if that is their preference and is feasible.
    - If the school district believes that the school selected is not in his/her best interest, then the district must provide the student with a written explanation of its position and inform the student of his/her right to appeal its decision.
- Receive transportation to and from the school of origin, if requested.
- Receive educational services comparable to those provided to other students, according to the student's needs.

If you believe you/your children may be eligible, please contact the district liaison at (989) 834-2271 extension 1000 to find out what services and supports may be available.

If you need further assistance with your educational needs, contact the National Center for Homeless Education: at 1-800-308-2145 or homeless@serve.org at w*ww*.serve.org/nche

Turn over and complete if the above is applicable to your family.

Ovid-Elsie Area Schools

MCKINNEY-VENTO QUESTIONNAIRE

STUDENT RESIDENCY

By completing this questionnaire, you help the district comply with the McKinney-Vento Act, Title X, Part C of the No Child Left Behind Act. Your truthful and accurate answers help the district identify services that the student may be eligible to receive.

Student's Name _____ ☐ Male ☐ Female Grade:

Parent/Legal Guardian Name _____ OR If Youth Is Unaccompanied (Check) ☐

Address (student is living at) _____

House Number Street City Zip Code

Telephone # _____

If the parent/guardian or unaccompanied youth has ever served in the military, please check this box ☐

If checked, are they active military now ☐ Yes ☐ No

1. **Where is the student living now?**

☐ In a shelter ☐ In a motel or hotel ☐ In a car ☐ Campsite/Campground (in a tent, RV, etc.)

☐ In a home lacking basic amenities (electricity, heat, running water, septic and/or bed for student, etc.

☐ ***With parent(s)/guardian(s) in the home of another adult that is a ☐ Family ☐ Friend

☐ ***Without parent(s)/guardian(s), but in the home of ☐ Family ☐ Friend

☐ **None of the above** (ie. lives in home/apartment with parent/guardian)

Additional Details

**RESIDENCY VERIFICATION AFFIDAVIT Required Please see complete page 2 if you selected either.*

2. **<u>If the student is new to the district,</u> to your knowledge, was the student listed as McKinney-Vento eligible in a previous district during <u>this</u> school year?**

☐ Yes ☐ No ☐ Unsure ☐ Not Applicable

If you checked "<u>None of the above</u>" for Question 1 and "<u>No</u>" for Question 2, you do not have to complete the remainder of this form. Please sign below and return this form to your school office.

3. **Is the living arrangement checked in question 1 due to a loss of housing or financial hardship on your family?**

☐ Yes ☐ No

4. **Names and ages of other children in the family (with same parent/guardian) living in this household:**

PARENT/LEGAL GUARDIAN'S SIGNATURE _____ **DATE** _____

FOR SCHOOL USE ONLY

<u>Please return a copy of this form to McKinney=-Vento Liaison. A copy must also be distributed to the Director of Food Service.</u>

____ Student is not covered by McKinney-Vento Act
____ Student is covered by McKinney-Vento Act
____ Student not currently MV, but eligible for services for the remainder of the school year based on status in a previous district.
____ Follow-up required
Contact person at the school who may know of the family's situation
Name _____ Phone # _____ Date Received _____

RESIDENCY VERIFICATION AFFIDAVIT

OVID-ELSIE AREA SCHOOLS

Name of Student _____

According to the State Attorney Opinion No. 5925 school districts have the right to ask new enrollees to prove residency. By signing this affidavit you are affirming that the address given on all enrollment forms is the legal residence of the parent enrolling the student.

If you are living in the home of another person without a rental or lease agreement, that person must provide proof of their residency, sign this document or provide a signed notarized letter stating that information.

Two proofs of residency are required, to include *at least one* of the following property-specific items:

☐ Property Tax Info ☐ Mortgage Info ☐ Purchase /Lease Agreement ☐ Utility Bill ☐ ClosingStatement

Other secondary proof may include:

☐ Driver's License ☐ Cell/Home Phone Bill ☐ Insurance Info ☐ Moving Bill ☐ Other

_____

Parent or Guardian

_____

Address/Street City Zip

_____

Signature of the person with whom residing (if applicable)

Ovid-Elsie Area Schools

STATE BOARD OF EDUCATION APPROVED HOME LANGUAGE SURVEY

Ovid-Elsie Area Schools is collecting information regarding the background of each of its students. This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1151 – 380.1157 of the School Code 1995, Would you please help by providing the following information?

This Home Language Survey has been developed for the purpose of identifying students who may need support in English in order to develop English language proficiency that will allow them to master grade-level curriculum. Your child may be given an English language proficiency screener, W-APT, in order to identify their English language proficiency. If the W-APT screener identifies the need for your child to receive ESL services, you will receive a Parent Notification Letter and an explanation of those instructional services.

Thank you very much for your cooperation.

Name of Student: _____
Grade: _____
School Building:_____

1. Is your child's native tongue a language other than English? ☐ Yes ☐ No
   If yes, what language? _____

2. Is the primary language[1] used in your child's home or environment a language other than English?
   ☐ Yes ☐ No
   If Yes, what language? _____

3. Have you or a family member worked in agriculture, poultry or dairy in the past three years?
   ☐ Yes ☐ No
   If yes, where did you work? _____

Signature of Parent or Guardian:

_____
Date:_____

Address:_____

1 "Primary language" means the dominant language used by a person for communication. "Translation of this survey form in Spanish, Arabic, French, Italian and Ojibwa is available at the Office of Field Services at 517-373-6066.

ENCUESTA SOBRE EL IDIOMA DEL HOGAR

Ovid-Elsie Area Schools necesita información acerca de le idioma que sus estudiantes hablan o entienden. Esta información sobre su hijo/hija será usada por el distrito escolar para determinar el número de estudiantes que pueden calificar para recibir educación bilingüe de acuerdo a las Secciones 380.1151 – 380.1157 del Código Escolar de 1995, Ley Sobre Educación Bilingüe de Michigan.

Esta encuesta sobre el idioma usado en casa fue hecha con el propósito de identificar a los estudiantes que talvez necesiten ayuda con el idioma inglés para poder dominar el idioma inglés y logar una comprensión completa del vocabulario académico usado en su grado actual. A su hijo/hija se le puede dar un examen de inglés llamado English language proficiency screener o mejor conocido como W-APT para poder demostrar su dominio del idioma inglés. Si el examen W-APT demuestra que su hijo/hija necesita ayuda para dominar el idioma inglés su hijo/hija tendría derecho a recibir apoyo de los servicios de ESL, y usted estaría recibiendo una carta notificándole de estos servicios y explicándole lo que estos servicios son.

Por favor responda a las preguntas que abajo se hacen. Muchas gracias por su cooperación.

Nombre del estudiante: _____
Grado: _____
Nombre de su escuela: _____

1. ¿Es el idioma nativo[1] (primer idioma) de su hijo/hija otro aparte del inglés? ☐ Si ☐ No
   ¿Cuál es ese idioma? _____

2. ¿Es el idioma principal[2] usado en la casa o "barrio" de su hijo(a) un idioma diferente al inglés?
   ☐ Si ☐ No
   ¿Cuál es ese idioma? _____

3. ¿A usted o alguien en su familia trabajado agricultura, una lechería, o con animales como pollos o cerdos en los últimos 3 años?
   ☐ Si ☐ No
   Si, su respuesta es sí. Cuando _____

Firma del padre/madre/guardián:

_____
Fecha:_____

Dirección:_____

1 "Idioma nativo" significa "el idioma primero en que el niño/la niña comenzó a entenderse con sus padres.
2 "Idioma principal" significa "el idioma dominante usado por una persona para comunicarse."

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

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

UNDERSTANDING CONCUSSION

Some Common Symptoms

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

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 or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay 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 healthcare professional says it's okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. 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
- Can't recall events prior to or after a hit or fall
- 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, rest is key. 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 rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a healthcare professional.

Remember: Concussion affects people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

To learn more, go to www.cdc.gov/concussion.

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

CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

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

_____	_____
Student's Name (Printed)	Parent or Guardian Name (Printed)
_____	_____
Student's Name (Signature)	Parent or Guardian Name (Signature)
_____	_____
Date	Date

Return this signed form to the sponsoring organization that must keep on file for the duration of participation or age 18. Participants and parents please review and keep the educational materials available for future reference.

Ovid Elsie Area Schools

Transportation Registration Form

To be completed ONLY IF you are requesting transportation services for your student.

Student's Name _____ **Grade** _____

Date of Birth _____ **Age on the first day of school** _____

Check School:

☐ LEO ☐ EEK

Check Program:

☐ KEEZ ☐ Marauder Kids

Each student is allowed one designated pickup location and one designated drop-off location.

MY CHILD IS RIDING AM:	☐ Yes	☐ NO

Pick-Up Address _____

House Number Street City Zip

Contact Person: _____ Phone Number: _____

This is: ☐ Home ☐ Daycare Other: _____

MY CHILD IS RIDING PM:	☐ Yes	☐ NO
Drop-off Address is same as Pick-Up	☐ Yes	☐ NO

Drop-off Address _____

House Number Street City Zip

Contact Person: _____ Phone Number: _____

This is: ☐ Home ☐ Daycare Other: _____

Names of other students at bus stop _____ Bus #: _____

Known Allergies: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone Number if not listed above _____

Ovid-Elsie Area Schools – Preschool/Childcare Participation

Student Legal Name: _____ **Gender: M___ F ___**
Last First MI Suffix

Preferred/Nick Name_____ **Birth date:** _____

Preschool/Childcare Participation - please check one

☐ My child did NOT participate in a preschool program or child care.

☐ My child DID participate in a preschool program or child care.
(If checked please continue)

Predominant Prior Care

☐ Great Start Readiness Program (GSRP)

☐ Head Start

☐ Private Child Care Center

☐ Tuition-Based Preschool

☐ Developmental Kindergarten/Young 5's

☐ GSRP/Head Start Blend

☐ Title I Preschool

☐ Family Child Care

☐ Early Childhood Special Education Classroom

Predominant Prior Care Delivery Method

☐ School

☐ Community Based

☐ Home Based

Predominant Prior Care Delivery Schedule

☐ Part-Day 4 Days Per Week

☐ Part-Day 5 Days Per Week

☐ School Day 4 Days Per Week

☐ School Day 5 Days Per Week

☐ Served by Family Child Care Center

Ovid-Elsie Area Schools

Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the students name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

I authorize Ovid-Elsie Area Schools to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.

Student's Name:_____ Date of Birth: __/__/__

Signature of Parent/Guardian or Eligible Student:_____ Date:__/__/__

Printed Parent/Guardian Name:_____ ___

Kindergarten Waiver Request for 2024-2025 School Year

Only complete if your child is not 5 years of age on September 1, 2024

Student Name: _____

According to Michigan Law, if a child residing in the Ovid-Elsie Area School district and is not 5 years of age on September 1, 2024 of the school year but will be 5 years of age not later than December 1, 2024 of the school year, the parent or legal guardian of that child may enroll the child in kindergarten for the current school year if the parent or legal guardian notifies the school district in writing that he or she intends to enroll the child in kindergarten.

A school district that receives this written notification may make a recommendation to the parent or legal guardian of a child described in this subsection that the child is not ready to enroll in kindergarten due to the child's age or other factors. The parent or legal guardian retains the sole discretion to determine whether or not to enroll the child in kindergarten if the student is 5 years of age not later than December 1, 2024.

Verification of Age (check one) **Date of Birth** ____/____/_____

- ☐ Birth Certificate
- ☐ Government Record
- ☐ Hospital Record
- ☐ Court Record
- ☐ Citizenship Paper
- ☐ Other:_____

Parent Name: _____

Evidence of School Readiness Provided by Parent/Guardian

1.	
2.	
3.	
4.	

Parent Signature: _____ **Today's Date:** _____

Ovid-Elsie Area Schools Recommendation

Administrators Name: _____

- ☐ Agrees with the recommendation of the parents to enroll your student in kindergarten.
- ☐ Recommends that your student begins kindergarten in September of next year for the following reasons:

1.	
2.	
3.	

Administrator's Signature: _____ **Today's Date:** _____