

Huron City Schools



Woodlands Elementary School
Committed to Academic Excellence

Lyle R. Rowe, Principal
Dayle Ritter, Guidance

REQUEST FOR RELEASE OR TRANSFER OF SCHOOL RECORDS

It is requested that an official copy of the school records of :

NAME OF STUDENT _____

BIRTHDATE _____

PRESENT GRADE: K / 1 / 2 / 3 / 4

SCHOOL LAST ENROLLED IN: _____

ADDRESS OF SCHOOL: _____

Release and /or transfer to : Woodlands Elementary School
1810 Maple Road
Huron, Ohio 44839

Please send cumulative records including intelligence and standardized test results, health records, attendance records and any other pertinent information, including IEP and Evaluation Team Reports.

Signature of Parent or Guardian

Signature of School Official

DATE MAILED FROM WDLS _____

RETURNED TO WDLS _____

Books returned:	Yes _____	No _____	Titles of books: _____
Fees paid:	Yes _____	No _____	Amount of fees due: _____

REGISTRATION FORM / HURON CITY SCHOOL DISTRICT

BUS # _____ STUDENT ID # _____ DATE ENTERING _____

SCHOOL YEAR 2006/ 2007 GRADE _____ TEACHER / ROOM # _____

**A student entering Huron City Schools for the first time must present birth certificate,
immunization record and custody papers (if applicable)**

LAST NAME _____ FIRST NAME _____ MIDDLE _____

ADDRESS _____ PHONE NO _____

CITY / STATE _____ ZIP CODE _____ IS # UNLISTED? _____

DATE OF BIRTH _____ MALE _____ FEMALE _____

PLACE OF BIRTH _____
(City) (County) (State)

RACE / ETHNICITY: White ___ Black ___ Hispanic ___ Asian/Pacific Islander ___ American Indian/ Alaskan Native ___

ENROLLED IN ANY OTHER PROGRAM: LD ___ DH ___ Speech ___ SBH ___ Other ___ Medications _____

FATHER'S NAME _____ ADDRESS _____

MOTHER'S NAME _____ ADDRESS _____

TITLE (CIRCLE ONE) MR. & MRS. MR. MRS. MS. MISS

RELATIONSHIP (CIRCLE ONE) PARENTS MOTHER FATHER GUARDIAN COURT

MAILING ADDRESS OF CUSTODIAL/RESIDENTIAL PARENT(S) OR GUARDIAN(S) _____

GUARDIAN(S) NAME (ONLY IF APPLICABLE) _____

IS THERE A COURT ORDER CONCERNING CUSTODY / GUARDIANSHIP OF STUDENT? YES ___ NO ___

If your child does not have custody papers on file, please indicate the reason below:

_____ No father is listed on the birth certificate.

_____ I was not married at the time of the child's birth, so custody is not applicable.

_____ My spouse and I are not living together, but there has been no legal action started that could result in custody awarded to the other spouse.

_____ Separation (divorce, dissolution, etc.) action has been started, but no final decree has been rendered. I will bring in the papers once they are complete.

ATTENDED KINDERGARTEN: Full Day _____ Half Day _____ Not at all _____

SCHOOL LAST ATTENDED _____ GRADE _____

SCHOOL ADDRESS _____ COUNTY _____

CITY / STATE / ZIP _____

PLEASE LIST OTHER IMMEDIATE FAMILY MEMBERS ENROLLED IN THE HURON SCHOOL SYSTEM _____

EMERGENCY DISMISSAL INFORMATION

Dear Parents,

During the course of the school year, it may become necessary to close school early due to weather conditions or other conditions which would make staying in school unsafe for students.

At such times, it is extremely difficult to contact parents by telephone to determine where each child should go. We are asking that you make advanced plans in the event they may be needed.

Please fill out the lower portion of this letter and discuss these plans with your child so that he/she understands and feels comfortable with them. Parents must return this form for each child.

Thank you for your cooperation.

EMERGENCY DISMISSAL INFORMATION

STUDENT'S NAME

TEACHER

Please check one of the following:

_____ There will be no change in my child's dismissal procedure. He/She will do what is normally done after school each day.

_____ My child will walk to : _____
Address Change

_____ My child will ride the same bus as usual with a different drop off point.
Address: _____

_____ No one is home to care for my child. My child will need a bus permit to ride a different bus to a different drop off point. Please send my child to:

Name: _____

Address: _____

Phone: _____

_____ Other (explain) _____

PARENT SIGNATURE _____

**On these early dismissal days, there will be no Tiger Kids Club after school.

PART II - REFUSAL TO GRANT PERMISSION:

I do **NOT** give my consent for emergency medical treatment of my child _____ .
Name of Child

In the event of an illness or injury which requires emergency medical or dental treatment, I wish the school authorities to take the following actions: _____

_____ Date _____ *Signature of Parent/Guardian

SCHOOL MEDICATION POLICY

It is the policy of the Huron City Schools that all children's medication be administered by a parent at home. Under exceptional circumstances medication may be administered by personnel providing the following state (Section 3313.713 of the Ohio Revised Code) and local regulations are met:

PARENTS AND PHYSICIAN MUST COMPLETE A "REQUEST FOR THE ADMINISTRATION OF MEDICATION FORM FOR PRESCRIPTION AS WELL AS NON-PRESCRIPTION MEDICATIONS (TYLENOL, ADVIL, ETC.). Forms are available at school and many health care provider's offices. Remember to ask for a written order if the medication will be required during school hours **BEFORE** you leave the doctor's office.

All medicine must be brought to the school office in the container in which it was dispensed or purchased and be clearly labeled with student's name. It will be the student's responsibility to come to the office for the medication at the appropriate time.

EMERGENCY MEDICAL AUTHORIZATION

ORC 3313.712

(A) Annually the board of education of each city, exempted village, local and joint vocational school district shall, before the first day of October, provide to the parent or legal guardian of every pupil enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into a public school in this state for the first time, provide his parent or legal guardian, either as part of any registration form which is in use in the district or as a separate form, an identical copy of the form contained in division (B) of this section.

When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a city, exempted village, local or joint vocational school district to which the pupil is transferred. Upon request of his parent or legal guardian, authorities of the school in which the pupil is enrolled may permit the parent or legal guardian to make changes in a previously filed form, or to file a new form.

If a parent or legal guardian does not wish to give such written permission, he shall indicate in the proper place on the form the procedure he wishes school authorities to follow in the event of a medical emergency involving his child.

Even if a parent or legal guardian gives written consent for emergency medical treatment, when a pupil becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extra-curricular activity authorized by the appropriate school authorities, the authorities of his school shall make reasonable attempts to contact the parent or legal guardian before treatment is given. The school shall present the pupil's emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section.

(B) The emergency medical authorization form provided for in division (A) of this section is as follows. (See reverse side)

OHIO SCHOOL HEALTH HISTORY

To be completed by parent or guardian

Date _____ Grade _____

Teacher _____

Child's full name _____

male _____ female _____ LAST FIRST MIDDLE

Birthdate: _____

Month Day Year

Child's address _____

Street City State Zip

Father's name _____

his address (if different from child's) _____

his work phone _____ his home phone _____

Mother's name _____

her address (if different from child's) _____

her work phone _____ her home phone _____

With whom does child live? _____

Name (s) Relationship

Who is this child's legal guardian? _____

Please list this child's brothers and sisters:

FAMILY HISTORY

	Birth year	Sex		Birth year	Sex
1.			4.		
2.			5.		
3.			6.		

*Has this child ever attended a public or private school in Ohio before? _____

PERINATAL HISTORY

Did the mother have any unusual physical or emotional illness during this pregnancy? Yes _____ No _____

If yes, explain briefly _____

How old was the mother when this child was born? _____

Was this infant born: full term _____ early _____ late _____ What was this infant's birth weight? _____

Did the infant have any sickness or problems while in the nursery? Yes _____ No _____

If yes, explain briefly _____

DEVELOPMENTAL HISTORY

Please give the approximate age at which this child:

walked alone _____ was toilet trained _____ spoke in sentences _____ dressed self _____

How does child's development compare to other children, such as his or her brothers / sisters or playmates?

about the same _____ slower _____ faster _____

Has your child attended nursery or pre-school? _____ Where? _____

When? _____ Child's reaction and progress _____

Has your child required treatment for any speech or hearing problems? _____ Explain _____

PLEASE COMPLETE OTHER SIDE

CHILD HEALTH HISTORY, CONTINUED: OHIO LAW ALLOWS A 14 SCHOOL DAY PERIOD FOR YOU TO PROVIDE A RECORD OF YOUR CHILD'S IMMUNIZATIONS.

I. HEALTH CONDITIONS - Please check any that this child has had:

- | | |
|------------------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Abnormal spinal curvature (scoliosis, etc) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Allergies or hayfever | <input type="checkbox"/> Kidney disease, type _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles-old fashioned or 10 day |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Meningitis or encephalitis |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Multiple ear infections (3+) |
| <input type="checkbox"/> Bedwetting at night | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Behavior problem | <input type="checkbox"/> Near-drowning or near-suffocation |
| <input type="checkbox"/> Birth or congenital malformation | <input type="checkbox"/> Nervous twitches or tics |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Chronic diarrhea or constipation | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures or epilepsy |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Eye problems, poor vision | <input type="checkbox"/> Substance abuse (alcohol, drugs) |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Frequent skin infections | <input type="checkbox"/> Toothaches or dental infections |
| <input type="checkbox"/> Frequent sore throat infections | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Heart disease, type _____ | <input type="checkbox"/> Wetting during the day |
| <input type="checkbox"/> Concern about relationship with siblings or friends | |

II. VISION AND HEARING

Frequent ear infections? _____ Which ear? _____ How often _____
 Reduction in hearing? _____ When? _____ P.E. Tubes? _____ In place? _____
 Wears glasses? _____ Reason _____ Last exam? _____

III. ALLERGIES - Please list and describe allergies or reactions to:

Medicines / drugs _____
 Foods / plants / animals / other _____
 Recommended treatment if allergy is severe _____

IV. INJURIES AND ILLNESSES - Please list any severe injuries or illnesses:

Injuries / Illnesses	Age of Child	If Hospitalized (check)
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. ADDITIONAL INFORMATION:

What medications are given daily? _____
 What medications are given frequently, but not daily? _____
 This child is usually: very active _____ normally active _____ rather inactive _____
 Do you have any concern about how your child gets along with other children? _____
 Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly: _____

Completed by: _____ Date: _____
 Relationship to child: _____

DATE OF LAST PHYSICAL EXAM _____ **DATE OF LAST DENTAL EXAM** _____