



Madison Local Schools

Raise Expectations, Increase Achievement, Prepare for Tomorrow ... *Make it Happen!*

PARENTAL CONSENT FOR RECORD RELEASE

PREVIOUS SCHOOL INFORMATION:

Name of Previous School: _____

Phone: _____

Address: _____

Fax#: _____

Student Name: _____

DOB: _____

I am the parent/legal guardian of the above named child and authorize you to release the following records to:

Madison Middle School 5/6 Phone: 419-589-1130 Fax: 419-589-1120
1419 Grace Street
Mansfield, Ohio 44905

Reason for request: Moved to the Madison Local School District, Mansfield, Ohio (District IRN = 049452)

Specific records/data to be released:

Academic Records	Health Records	Psychological Records
TGRG (K-3) All Diagnostics	Assessment Scores	I.E.P./MFE/other applicable placement forms
RIMP (if applicable)	Grade Cards	School Records from previous school districts
Birth Certificate	Custody Papers	Discipline Records

Date: _____

Parent/Guardian Signature: _____

Print Name of Parent/Guardian: _____

Address: _____

(New address in the Madison Local School District)

Phone: _____

Enrollment Date _____ Teacher _____ ID ## _____

MADISON LOCAL SCHOOLS PUPIL HISTORY BLANK

Student Name _____ Grade _____
(Last) (First) (Middle)

Address _____ Phone _____

(City) (Zip) Male _____ Female _____

Social Security Number _____ Birthdate _____

Place of Birth _____
(City) (County) (State)

Student Lives With: Are parents married? _____

- ____ Mother & Father
- ____ Mother Alone*
- ____ Father Alone*
- ____ Mother & Stepfather*
- ____ Father & Stepmother*
- ____ Foster*
- ____ Legal Guardian* (Are they a relative? Yes No)
- ____ Other* (_____)

*Custody paper are mandatory UNLESS mother was not married at the time of the child's birth.

Name of Person Student Lives With: 1) _____

(Place of Employment) (Phone)
2) _____

(Place of Employment) (Phone)

Student Race/Ethnic Origin: White, Non Hispanic _____ Black, Non Hispanic _____
Multiracial _____ Asian/Pacific Islander _____
American Indian or Alaskan Native _____

Name & Address of School Last Attended: _____

(Street Address) (Name of School)

(City, State, Zip)

Enrollment Date _____ Teacher _____ ID ## _____

Has student ever attended another school in Madison District: _____

If yes, School _____ Dates? _____

Does this student have a current IEP? Yes _____ * No _____

*(Please provide a copy if available)

If yes, what is it for
Speech _____ LD _____ DH _____
OT _____ PT _____ SBH _____
504 Plan _____ OHI _____ Don't Know _____
Other _____

If yes, was this child in: (Circle One) Inclusion Room Self Contained

SIBLING INFORMATION:

School: _____

- 1. _____ Sister/Brother Younger/Older _____
- 2. _____ Sister/Brother Younger/Older _____
- 3. _____ Sister/Brother Younger/Older _____
- 4. _____ Sister/Brother Younger/Older _____
- 5. _____ Sister/Brother Younger/Older _____
- 6. _____ Sister/Brother Younger/Older _____

Is there any other information about your child you would like us to know? _____

Is there any other information about your family you would like us to know? _____

Is your child currently taking any medication? _____ Name of Medicine _____

When taken? _____

Ohio Department of Health • School and Adolescent Health

Health History

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

Father
Mother
Brothers and Sisters

Birth and Developmental History. No unusual birth or developmental history

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

Student Health Conditions

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

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.	Allergy type	Reaction	School restrictions or recommended actions
<input type="checkbox"/>	Bee/insect		
<input type="checkbox"/>	Food		
<input type="checkbox"/>	Medication		
<input type="checkbox"/>	Other		

STUDENT NAME _____

GRADE _____

DATE _____

FILL OUT BOTH PARTS – (Federal Government Requirement)

Is the student of Hispanic/Latino Heritage? Yes No

- *Hispanic/Latino means a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race*

Part I – Ethnic Category – Choose One:

- White Black/African American Hispanic/Latino Multi-Racial Asian
 Native Hawaiian or Pacific Islander American Indian or Native Alaskan

Part II – Racial Group – Choose one or more Racial Groups:
(Racial Group Descriptions listed at bottom of page)

- White Black /African American Native Hawaiian or Pacific Islander
 American Indian or Native Alaskan Asian

If ethnicity/race information is not provided by parent/guardian, the school district shall use visual identification and report their best estimate. See below for racial group descriptions.

I choose not to answer one or more of the above categories. I understand the school district will choose the category that best applies based on visual identification.

Student/Parent/Guardian Signature: _____

White –
Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Black or African American –
Persons having origins in any of the black racial groups in Africa.

Asian –
Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

American Indian or Alaskan Native –
Persons having origins in any of the original peoples of North and South American (including Central America) who maintain tribal affiliation or community attachment.

Native Hawaiian or Other Pacific Islander –
Persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Multiracial –
Persons having origins in two or more of the above options.

HOME LANGUAGE SURVEY

(As mandated by Federal Law - NCLB)

Date: _____ Grade: _____

Enrolling School: _____

Name of Student: _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____ / _____ / _____ Age: _____
Month Day Year

Place of Birth: _____
(City) (State) (County)

Name of Parent/Guardian: _____
(Last Name) (First Name)

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Is an interpreter needed? Name: _____ Phone: _____

Circle your child's dietary needs: No Restrictions Vegetarian No Pork Products

List Food Allergies: _____

Please answer the following questions:

1. What language did your son/daughter speak when he/she first learned to talk? _____
2. What language does your son/daughter use most frequently at home? _____
3. What language do you use most frequently to your son/daughter? _____
4. What language do the adults at home most often speak? _____
5. How long has your son/daughter attended schools in the United States, including preschool? _____

MADISON LOCAL SCHOOLS
SPEECH LANGUAGE AND HEARING SURVEY

Child's Name _____ Today's Date _____
Date of Birth _____

Parent's Name _____ Phone _____

PLEASE FILL IN APPROPRIATE AREAS:

HEARING

_____ Tubes Dr. _____ When _____

_____ Child has history of ear infections. If so, approximate number _____

_____ Hearing Loss. Describe _____

SPEECH AND LANGUAGE

_____ Has received Speech services. Where _____
When _____ How Long? _____

_____ Is now receiving speech services. Where _____

_____ Difficulty producing speech sounds. List examples _____

_____ Omits words or word endings.

_____ Doesn't use complete sentences.

_____ Voice problem. Describe _____

_____ Cleft palate and/or cleft lip. Describe Medical Treatment _____

_____ Does your child presently stutter?

PLEASE ADD ANY ADDITIONAL COMMENTS:

MADISON LOCAL SCHOOLS
EMERGENCY MEDICAL FORM - School Year 2017-2018

Student Information: *Please keep school advised of address and phone number changes.*

Student Name: _____ Date of Birth: _____ Grade: _____
Address: _____ Phone: _____

Facts about your child's medical history to which the school and/or a physician should be alerted: (example: medical conditions, physical impairments, food allergies, other allergies, medications (including purpose and dosage), and any other pertinent information:

*** * * CONTACT INFORMATION * * ***

Only those listed on this form are authorized to pick up this student. Student will not be released to anyone not showing photo identification. If needed, additional contact information may be added on the back of this page.

Parent/Guardian Child Lives With:

Name: _____
Relationship: _____
Address: _____
Cell# _____ Home# _____
Email: _____
Place of Employment: _____
Work#: _____

Name: _____
Relationship: _____
Address: _____
Cell# _____ Home# _____
Email: _____
Place of Employment: _____
Work#: _____

Alternate Contacts

Name: _____
Relationship: _____
Address: _____
Cell# _____ Home# _____

Name: _____
Relationship: _____
Address: _____
Cell# _____ Home# _____

Medical Consent: The following physicians have consent to treat your child in case of emergency:

Doctor: _____
Dentist: _____
Medical Specialist: _____
Preferred Hospital: _____

Phone Number: _____
Phone Number: _____
Phone Number: _____
Phone Number: _____

Consent/Refusal - This must be completed – Please check one of the following & sign below:

In the event reasonable attempts to contact me have been unsuccessful, **I HEREBY GIVE CONSENT** for the (1) administration of any treatment deemed necessary by the above named physicians for dentist, and (2) the transfer of child to any hospital reasonably accessible.

Note: This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

I DO NOT GIVE CONSENT for emergency medical treatment of my child. In the event of an illness or injury requiring emergency treatment, I request that the school authorities take the following action: _____

Parent/Guardian Signature: _____ **Date:** _____ **See Back** 

**Madison Local School District
Standard Release Form**

In an effort to maintain the integrity and goals of the Madison Local School District, the following form must be completed before any information is published which contains a staff member's photograph, a student's photograph, or a student's work.

Please complete this form and return it to your student's school office.

I (do ___/ do not ___)J authorize the release of my picture for use on school/district publicity or publications, videos or the district web site.

I (do ___/ do not ___)J authorize the release of my intellectual property such as art work, poetry, essays, performances, etc. to be used on school/district publicity or publications, videos or the district web site.

Name (Please Print) _____

Signature _____ Date _____

If under age 18, please complete this section.

Parent/Guardian Name (Please Print) _____

Parent/Guardian Signature _____ Date _____

**Acceptable Use and Internet Safety Policy
of the
Madison Local School District
STUDENT'S AGREEMENT**

(Every student, regardless of age, must read and sign below)

I have read, understand and agree to abide by the terms of the foregoing Acceptable Use and Internet Safety Policy. Should I commit any violation or in any way misuse my access to the School District's computer network and the Internet, I understand and agree that my access privilege may be revoked and School disciplinary action may be taken against me.

Student Name (PRINT CLEARLY) _____

Home Phone _____

Address _____

Date _____

Place an "X" in the correct blank: I am 18 or older _____ I am under 18 _____

If I am signing this Policy when I am under 18, I understand that when I turn 18, this Policy will continue to be in full force and effect and agree to abide by this Policy.

Student's Signature _____

**PARENT'S OR GUARDIAN'S AGREEMENT
(To be read and signed by parents or guardians of students who are under 18)**

As the parent or legal guardian of the above student, I have read, understand and agree that my child or ward shall comply with the terms of the School District's Acceptable Use and Internet Safety Policy for the student's access to the School District's computer network and the Internet.

I understand that access is being provided to the students for educational purposes only. However, I also understand that it is impossible for the School to restrict access to all offensive and controversial materials and understand my child's or ward's responsibility for abiding by the Policy.

I am therefore signing this Policy and agree to indemnify and hold harmless the School, the School District and the Data Acquisition Site that provides the opportunity to the School District for computer network and Internet access against all claims, damages, losses and costs, of whatever kind, that may result from my child's or ward's use of his or her access to such networks or his or her violation of the foregoing Policy. Further, I accept full responsibility for supervision of my child's or ward's use of his or her access account if and when such access is not in the School setting.

I hereby give permission for my child or ward to use the building-approved account to access the School District's computer network and the Internet.

Parent or Guardian Name(s) (PRINT CLEARLY) _____

Home Phone _____

Address _____

Date _____

Parent or Guardian Signature(s) _____

MADISON LOCAL SCHOOL DISTRICT

BUS STOP AUTHORIZATION FORM

It is the intent of the Madison Local School District to ensure that students who are transported are safely picked up, transported to school and returned to their home's, or other designated drop off points each day.

To assist us in achieving this, we need approval regarding the following:

STUDENT: _____

AM Pick-up Address: _____

PM Drop-off Address: _____

_____ My Son/Daughter WILL NOT BE RIDING The Bus

IT IS NECESSARY THAT EACH PRE-SCHOOLER/KINDERGARTNER BE PUT ON THE BUS AND MET ON THE RETURN. A designated responsible persons list should be added to the yellow card you will be given from the school upon registration in August. Any changes or additions to the responsible persons list should be maintained with the school.

In the event there isn't an accompanying sibling or responsible person at the drop-off site when the bus arrives, the child will be taken to the:

Madison Child Care Center 103 Bahl Ave 419-589-7851 or OTHER ASSIGNED LOCATION,

where a designated responsible person will be required to pick up the child. A charge will be assessed after the first time of use of the center.

Signature of Parent or Guardian: _____

Address _____

Phone _____ Date _____

This form must be completed and returned before your child will be transported to or from school. In the event that any of this information should change between your child's registration and when school starts, or any time through the school year, please contact the child's school and the Bus Garage @ 419-589-3473 and give them the information immediately. Thank you.