Austintown Local School District
2020-2021 Student Registration Form
Please print as neatly as possible

Student Status (pick circle one): Resident of Austintown Open Enrollment (attending Austintown)
Open Enrollment Out (District Attending)_____ Other:_____

Student Name
(Legal Name)_____
First Middle Last
Parent/Guardian
Name:_____

Student Date of Birth:_____ Birthplace(City/State or Country):_____

Citizen of the U.S: Yes or No Active Military Parent: Yes or No

Gender: Male or Female Grade Level in 2020-2021: ____

Home Phone:_____ Cell Phone: _____

Home Address:_____Apt_____

City_____State_____Zip_____

*Is the Student Hispanic/Latino? Yes or No
*Is the Student from one or more of the following (Circle all the apply).
*Race: Asian, Black, American Indian/Alaskan Native Native, Hawaiian/Other pacific Islander or White

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Has the Student ever been
*Retained (repeated a grade):Yes or No If yes, Grade:_____
*Does the Student Currently Receive Special Services: yes or No If yes, please circle below:
Gifted(WEP) IEP Limited English(English Learner Plan) 504 Plan
*Suspended/Expelled from School? Yes or No

I understand that students whose parents are found, after appropriate investigation, to have submitted fraudulent information in an effort to enroll a student in which the student in not assigned, shall be immediately withdrawn by the school and the parent must enroll the student in the appropriate school.

Parent/Guardian Signature_____Date:_____

Revised 12/6/19

Austintown Local School District Emergency Medical Form (School Year 2020-2021)

*The State of Ohio requires the Emergency Medical Form be updated

For School Use Only:
Homeroom #_____

Student Information		
Student Name:	❑ **Male** ❑ **Female** **Date of Birth:**	**Grade:**
Student Address:	**City/State:**	**Zip**

Residential Parent/Guardian Information (please answer Questions A, B, & C)	
A. Student lives with (CIRCLE one): Both Parents *or* Mother Only *or* Father Only *or* Other:_____ **Active Military**: Yes *or* No, If yes,: Mother *or* Father *or* Both *or* Other:_____	**B. Are the student's parents/guardians (CIRCLE one):** Married *or* Divorced *or* Separated *or* Never Married Otherwise living separately, please explain:_____
C. Who has legal custody for child(ren) (CIRCLE one): Both Parents *or* Mother Only *or* Father Only *or* Shared *or* Other:_____	**If Separated or Divorced, Custody Papers are Required for Student File.** **For Shared Custody, provide addresses of both parents below.**

Legal Parent/Guardian Information	***Legal Parent/Guardian Information***
Name:	**Name:**
Cell Number:	**Cell Number:**
Home Number:	**Home Number:**
Primary Email:	**Primary Email:**
Relationship to Student: Mother / Stepmother / Foster Mother / Grandmother / Father / Stepfather / Foster Father / Grandfather / Guardian **(Circle one)**	**Relationship to Student:** Mother / Stepmother / Foster Mother / Grandmother / Father / Stepfather / Foster Father / Grandfather / Guardian **(Circle one)**
Is your address the same as the student?(Circle one) Yes *or* No **If No, list your current Address, City, State , Zip:**	**Is your address the same as the student?(Circle one)** Yes *or* No **If No, list your current Address, City, State , Zip:**

Emergency/Alternate Contacts

In the event you are unable to contact me at the above numbers, you have my permission to contact the following alternates. They have my permission to receive health care information regarding my child and can take my child home during school hours if needed.

Contact 1 (other than Parent/Guardian)	***Contact 2 (other than Parent/Guardian)***
Name:	**Name:**
Relationship:	**Relationship:**
Best Contact Number:	**Best Contact Number:**
Contact 3 (other than Parent/Guardian)	***Contact 4 (other than Parent/Guardian)***
Name:	**Name:**
Relationship:	**Relationship:**
Best Contact Number:	**Best Contact Number:**

Emergency Authorization

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by named doctor below, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. 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.

Consent Given (Circle one): Yes (if Yes, please list "Medical Contacts" below) or No (if No, please complete "Consent Refusal Instructions" below)

Doctor Name:	**Doctor Phone:**	
Dentist Name:	**Dentist Phone:**	
Hospital Name:	**Hospital Phone:**	**Branch:**
Consent Refusal Instructions:		

Parent/Guardian Signature: _____ **Date:** _____ ***TURN OVER***

Austintown Local School District Health Information (School Year 2020-2021)

Student Name:_____ **Grade:**_____

Your child's health and education are very important to us. The information below will be used to facilitate your child's learning. Informing and educating staff about your child's needs will help promote his/her wellbeing. Confidentiality will be maintained and the information will be shared with those responsible for meeting the child's health care needs.

1. Peanut Allergy?	**Yes or No**	**Describe Reaction:**_____ _____ **Difficult breathing? Yes or No Emergency Medication? Yes or No** **Do you eliminate all peanut-containing food? Yes or No**
2. Other Food Allergy?	**Yes or No**	**Food?**_____ **Describe Reaction:**_____ **Difficult Breathing? Yes or No Emergency Medication? Yes or No**
3. Allergy?	**Yes or No**	**Medications, seasonal or environmental? List:**_____ _____ **Has allergy required emergency care in the past? Yes or No** **Comments:**_____
4. Sting Allergy?	**Yes or No**	**Bee/insect?** _____ **Describe reaction:**_____ **Difficult breathing? Yes or No Emergency Medication? Yes or No**
5. Diabetes?	**Yes or No**	**DIABETES MANAGEMENT PLAN FROM DR AND SUPPLIES MUST BE IN CLINIC BY THE FIRST DAY OF SCHOOL.**
6. Asthma?	**Yes or No**	**Inhaler? Yes or No, Kept in Clinic? Yes or No, Self-Carry? Yes or No**
7. Epilepsy/seizures?	**Yes or No**	**Emergency medication? Yes or No**
8. Heart Condition	**Yes or No**	**Describe:**_____ **Activity restrictions? Yes or No Describe:**_____ _____
9. Other? (any other health information you would like us to know about your child)	**Yes or No**	**Describe:**_____ _____ _____

Please check ALL that apply regarding your child's vision and hearing:

Eyes: **___Lazy Eye ___Crossed ___Difficulty Seeing ___Glasses ___Contacts**

Ears: **___Frequent Infections ___Tubes ___Hearing Difficulty ___Hearing Aid for: ___Right Ear ___Left Ear**

***Vision Screenings will be performed in grades K,1,3,5,7,9,11**

***Hearing Screenings will be performed in grades K,1,3,5,9,11**

Daily Medications Taken by Student

Requirements for Medications to be administered at school:

A. **It is strongly recommended to parents, with their physician's counsel, that the medication schedule should be adjusted to avoid administering medication during school hours.**
B. **If this is not possible, then the Medication Authorization Form must be filed with the respective building health clinic before the student will be allowed to take medication during school hours. This written and signed request form is to be submitted each school year.**

Name of Medication:	Reason for Taking:	Taken where?
		Home and/or School
		Home and/or School

Does your student require special health care? Yes or No If yes, please explain:_____

Circle Yes or No for the following questions:

1. The Austintown Local School District Nurses (or other trained personnel) may administer acetaminophen (Tylenol) for orthodontics, headaches, and menstrual cramps during this school year with signed parental permission, up to 3 doses then medicine needs to be provided from home (This applies to grades 4-12). **YES or NO**
2. The Austintown Local School District Nurses (or other trained personnel) may administer TUMS for complaints of heartburn, sour stomach, or acid indigestion with signed parental permission, up to 3 doses then medicine needs to be provided from home. (This applies to grades 4-12). **YES or NO**
3. The Austintown Local School District Nurses (or other trained personnel) may administer Benadryl for emergency reaction only during this school year with signed parental permission, do you give consent? **YES or NO**
4. The Austintown Local School District Nurses (or other trained personnel) may apply anti-itch lotion for skin irritations during this school year with signed parental permission, do you give consent? **YES or NO**
5. The Austintown Local School District Nurses (or other trained personnel) may apply sting relief antiseptic for insect bites during this school year with signed parental permission, do you give consent? **YES or NO**
6. BMI Screening (Body Mass Index screening for Grades Kg, 3rd, 5th, & 9th). Part of Healthy Choices for Healthy Children Act. Do you give consent to have this screening done? **YES or NO**
7. May your 5th Grade student attend the boy's or girl's puberty education program presented by a District Registered Nurse? **YES or NO**

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

2020-2021 SCHOOL YEAR KINDERGARTEN PARENTS

PLEASE LOOK AT YOUR CHILD'S IMMUNIZATION (SHOT) RECORD WHILE YOU ARE HERE AT REGISTRATION.

If you do not have your child's immunization (shot) record with you, you will be asked to return with it in order to register your child for Kindergarten. If you child's record is incomplete, please make certain you make an appointment to have the remaining immunizations ***before*** school starts. You may do that by calling:

Your child's physician OR
Mahoning County Board of Health: 330-270-2855 ext 125.

Kindergarten Immunization Requirements

Four (4) or more of DTaP or DT, or any combination. If all four doses were given before the 4th birthday, a fifth (5) dose is required. If the fourth dose was administered at least six months after the third dose, and on or after the 4th birthday, a fifth (5) dose is not required.*

Three (3) or more doses of IPV (polio). The FINAL dose must be administered on or after the 4th birthday regardless of the number of previous doses. If a combination of OPV and IPV was received, four (4) doses of either vaccine are required.***

Two (2) doses of MMR. Dose 1 must be administered on or after the first birthday. The second dose must be administered at least 28 days after dose 1.

HEP B Hepatitis B K-12 Three (3) doses of Hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the series (third or fourth dose), must not be administered before age 24 weeks.

Two (2) doses of varicella vaccine must be administered prior to entry. Dose 1 must be administered on or after the first birthday. The second dose should be administered at least three (3) months after dose one (1); however, if the second dose is administered at least 28 days after first dose, it is considered valid.

(See Board Policy on Back)

1/21/15 **OSBA** **File: JHCB**

IMMUNIZATIONS

In order to minimize the spread of preventable illnesses in schools and provide students with a healthier learning environment, the Board requires immunizations in compliance with State law and the Ohio Department of Health for each student unless the parent(s) file an objection. The Board may also require tuberculosis examinations in compliance with law.

Students eligible for kindergarten and students new to the District must present written evidence of similar immunizations, or written evidence to indicate that they are in the process of receiving immunizations, to be completed no later than the day of entrance. Students failing to complete immunizations within 14 days after entering are not permitted to return to school.

The District maintains an immunization record for each student, available in writing to parents upon request.

[Adoption date: September 19, 2006]
[Re-adoption date: March 22, 2010]
[Re-adoption date: August 17, 2010]

LEGAL REFS.: ORC 3313.67; 3313.671; 3313.71; 3313.711
3701.13

CROSS REFS.: JEC, School Admission
JHCA, Physical Examinations of Students
JHCC, Communicable Diseases

THIS IS A REQUIRED POLICY

Family Survey

1. My Zip Code is _____.

2. Ages and when my child(ren) enrolled in DPIL_____.

3. How many children's books do you have at home?
   □ 1-10 □ 10-20 □ More than 20

4. Do you read to your child more often since enrolling in the DPIL?
   □ Yes □ No □ About the same

5. How often do you read to your child in an average week?
   □ Once □ 2-6 Times □ Every day

6. How excited is your child about books/reading?
   □ Very excited □ Excited □ Somewhat excited □ Not excited

7. How important do you feel reading books are to your child's development?
   □ Very important □ Important □ Somewhat important □ Not important

8. Does your child look forward to the arrival of a book each month?
   □Yes □No

9. Do you think being in DPIL has/will help prepare your child for kindergarten?
   □Yes □No

10. Have you encouraged other families to sign up for DPIL?
    □Yes □No