Lakewood Public Schools

Welcome to Lakewood! Enclosed are the registration forms to be completed for your student(s). Below is a list to assist you in the registration process. Please return all enrollment materials to the building your student will be attending.

STUDENT REGISTRATION CHECKLIST

_____ Fill out all enrollment forms

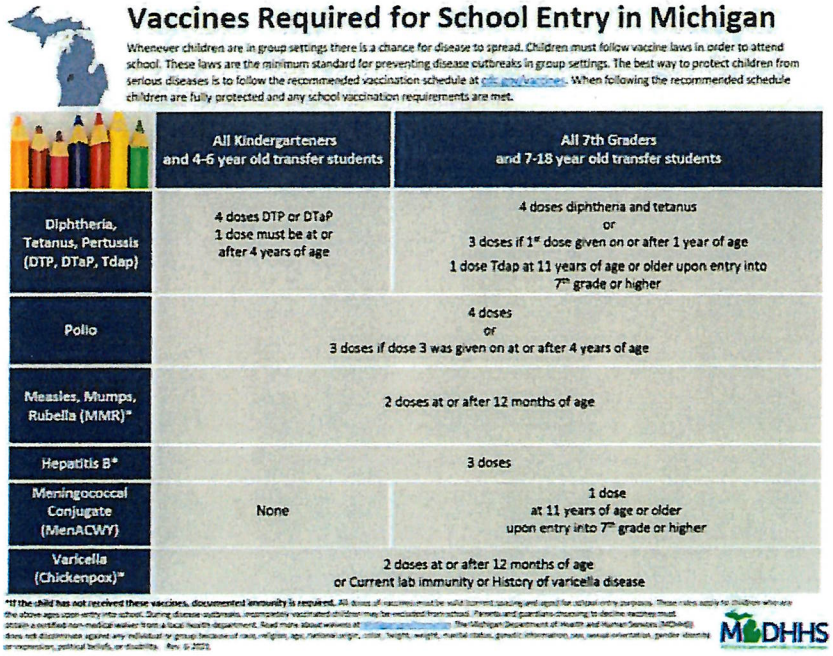
- Student Registration Form
- Record's Request Form
- Home Language Survey
- Concussion Form
- Permission to Place – *Only required if student receives special education services.*

_____ Obtain Certified Birth Certificate Copy

State law requires that a certified birth certificate copy (with raised seal) be presented as proof of age for your student. Certified birth certificates were available from the county clerk in the county in which your child was born. **Law requires that a state or county certified original be presented at registration. No copies will be accepted. As the law states, we can*not* accept birth certificate copied and transferred from another school.** If you need assistance obtaining your student's birth certificate, please contact the school's secretary. Phone numbers can be found in this packet on the request for records form.

_____ Updated Immunization Record

By law, all waivers must be obtained directly from your county health department. Check to see if your child has had the following immunizations:



Vaccines Required for School Entry in Michigan

Whenever children are in group settings there is a chance for disease to spread. Children must follow vaccine laws in order to attend school. These laws are the minimum standard for preventing disease outbreaks in group settings. The best way to protect children from serious diseases is to follow the recommended vaccination schedule at cdc.gov/vaccines. When following the recommended schedule children are fully protected and any school vaccination requirements are met.

	All Kindergarteners and 4-6 year old transfer students	All 7th Graders and 7-18 year old transfer students
Diphtheria, Tetanus, Pertussis (DTP, DTaP, Tdap)	4 doses DTP or DTaP 1 dose must be at or after 4 years of age	4 doses diphtheria and tetanus or 3 doses if 1st dose given on or after 1 year of age 1 dose Tdap at 11 years of age or older upon entry into 7th grade or higher
Polio	4 doses or 3 doses if dose 3 was given on at or after 4 years of age	
Measles, Mumps, Rubella (MMR)*	2 doses at or after 12 months of age	
Hepatitis B*	3 doses	
Meningococcal Conjugate (MenACWY)	None	1 dose at 11 years of age or older upon entry into 7th grade or higher
Varicella (Chickenpox)*	2 doses at or after 12 months of age or Current lab immunity or History of varicella disease	

*If the child has not received these vaccines, documented immunity is required. All doses of vaccine must be valid (correct spacing and age) for school entry purposes. These rules apply to children who are the above ages upon entry into school. During disease outbreaks, incompletely vaccinated children may be excluded from school. Parents and guardians choosing to decline vaccines must obtain a certified non-medical waiver from a local health department. Read more about waivers at [illegible]. The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability. Rev. 9 2021

MDHHS

if

_____ Proof of residency

___ own or rent – Documents required - driver's license with current address and/or utility bill

___ living with another family – Documents required - driver's license with a letter from owner of house in which you are living. Appointment required with McKinney-Vento Director, Keith Carpenter, (616) 374-8842.

___ other – Court documents may be accepted.

Lakewood Public Schools

REQUEST FOR RECORDS

Name of Previous School _____

Address _____

City, State, Zip _____

Telephone Number _____ Fax Number _____

Parent/Guardian Signature _____

Student's Name	_____	Grade	_____	Birth Date	_____
Student's Name	_____	Grade	_____	Birth Date	_____
Student's Name	_____	Grade	_____	Birth Date	_____
Student's Name	_____	Grade	_____	Birth Date	_____

This is to certify that the parent/guardian of the above named students request release of **ALL** of the following information to the school indicated below:

- Discipline Records
- Medical/Health Information
- Teacher Reports (grades, attendance, achievement, test records, etc.)
- Special Education, IEP, etc
- Psychologist and/or Social Worker Reports
- Current school program/recommendations

PLEASE SEND RECORDS TO:

_____ **LAKEWOOD ELEMENTARY**
Grades 1st - 4th
Student Records Department
812 Washington Blvd., Lake Odessa, MI 48849
Phone (616) 374-8842
Fax (616) 374-1499
email: penningtonj@lakewoodps.org

_____ **LAKEWOOD EARLY CHILDHOOD CENTER**
Grades Preschool - Kindergarten
Student Records Department
223 W. Broadway, Woodland, MI 48897
Phone (269) 367-4935
Fax (269) 367-4771

_____ **LAKEWOOD HIGH SCHOOL**
Grades 9th - 12th
Student Records Department
7223 Velte Road, Lake Odessa, MI 48849
Phone (616) 374-8868 Fax (616) 374-1477

_____ **LAKEWOOD MIDDLE SCHOOL**
Grades 5th - 8th
Student Records Department
8699 Brown Road, Woodland, MI 48897
Phone (616) 374-2400
Fax (616) 374-2424

According to the Final Regulation-Family Educational Rights and Privacy Act (Final Rule on Education Record, Federal Register, June 18,1976, Vol. 41, No. 118, 24673), it is **no longer necessary to obtain written consent to release records between schools.** It states that school officials, including parents within the educational institution and officials of other school systems in which the student may intend to enroll, may receive a students' record without written consent for such release.

REQUEST FOR RECORDS SENT ON ____/____/20____ BY _____, Building Registrar

Lakewood Public Schools

Student Registration Form

School Use Only:
Student #:
UIC #:
☐ MICR ☐ Honeywell
☐ Spec. Ed ☐ 504
Homeroom:

Student Information: ***Please print***

Last: First: Middle:

Address (no PO Boxes):

City: State: Michigan Zip:

County of Residence: ☐Barry ☐Eaton ☐Ionia ☐Kent Township of Residence:

Mailing Address *(if different):*

Home Phone: Birth City:

☐ Male ☐ Female Birth date: / / **Grade Entering:**

SPECIAL NEEDS of new student enrolling if any:
(circle all that apply) Vision Hearing Speech Allergies Special Education Medications

Medical Conditions:

student have an IEP or 504 Plan at previous schoc ☐ Yes ☐ No If yes, complete the Permission to Place form attached to enrollment packet.

Ethnicity
Is this student Hispanic/Latino? (Choose only one)
☐No, not Hispanic/Latino
☐Yes, Hispanic/Latino-(A person of Cuban, Mexican, Puerto Rican, South/Central American, or other Spanish culture or origin, regardless of race.)

Race
The question to the left is about ethnicity, not race. No matter what you selected, **please continue to answer the following** by marking one or more boxes indicated what you consider your student's race to be.
☐ American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐White
☐ Asian American ☐ Black/African American

School most recently attended:		City & State		Last Grade Completed:	

Family Information: ***(check the best answer)***	Own or Rent ☐	Living w/ another family ☐	Shelter ☐	Hotel/Motel ☐	Unknown ☐	Other Location ☐	Temporary Location ☐

Student resides with: Name Relationship

Parent/Guardian - A: Birth date:

Address:

City: State: Zip:

Home Phone: Work Phone:

Cell Phone: E-Mail Address:

Employer & Occupation:

Parent/Guardian - B: Birth date:

Address:

City: State: Zip:

Home Phone: Work Phone:

Cell Phone: E-Mail Address:

Employer & Occupation:

Step-parent - A, Court Appointed Guardian or Case Worker Information if applicable:

Name: Birth date:

Address:

City: State: Zip:

Home Phone: Work Phone:

Cell Phone: E-Mail Address:

Employer & Occupation:

Step-parent - B, Court Appointed Guardian or Case Worker Information if applicable:

Name: Birth date:

Address:

City: State: Zip:

Home Phone: Work Phone:

Cell Phone: E-Mail Address:

Employer & Occupation:

Emergency Information: (Family member/friend to contact after your home/work has been tried.)

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:

Please list all children in the family even if they are not in school.

Name:	Grade:	Birth date:
Name:	Grade:	Birth date:
Name:	Grade:	Birth date:
Name:	Grade:	Birth date:
Name:	Grade:	Birth date:
Name:	Grade:	Birth date:

Transportation Information

Will this student ride the bus to school from Home Childcare Neither (please circle one)

Will this student ride the bus from school to Home Childcare Neither (please circle one)

If applicable:

Childcare Provider's Name: Phone:

Address (NO PO Boxes): City/Zip:

Parent/Guardian Signature: Date:

FOR SCHOOL USE ONLY:

School assigned to: LHS LMS LES LECC

Sent to School & Transportation: ___/___/___

Parent anticipating call with information for schooling and transportation information? Transportation Yes☐ No☐ School Yes☐ No☐

Lakewood Public Schools Emergency Contact Information 2023-2024

Student ID: _____ Teacher: _____

Student's Information: (Please Print Legibly)

Name: (Last)_____ (First)_____ Middle _____

Other Name/Nickname: _____ Date of Birth: _____ Female / Male (please circle)

Address: _____ City:_____ Zip:_____

County: _____ Is this student a ward of the Court? YES / NO (please circle), if yes please list:

County_____ Case Worker's Name & Number: _____

Student Resides With: Mother / Father / Both / Other _____

Mother: (Last)_____ (First)_____ Date of Birth_____

Street Address:_____ City:_____ Zip: _____

Home phone #: _____ Cell #: _____

Work #: _____ Ext: _____ Which phone number is best to reach you during school hours? _____

Mother's Email Address (**REQUIRED**):_____

Father:(Last)_____ (First)_____ Date of Birth_____

Street Address: _____ City:_____ Zip:_____

Home phone #: _____ Cell #: _____

Work #: _____ Ext: _____ Which phone number is best to reach you during school hours? _____

Father's Email Address (**REQUIRED**):_____

Step-Father: (Last)_____ (First)_____

Street Address: _____ City: _____ Zip:_____

Cell #: _____

Step-Mother: (Last)_____ (First)_____

Street Address: _____ City: _____ Zip:_____

Cell #: _____

CONTINUED ON THE REVERSE SIDE

Office Use Only Date Entered: _____

Lakewood Public Schools Emergency Contact Information 2023-2024

Please list three (3) people who will assume temporary care of your child if **you cannot be reached** (note: these contacts will be called in the order you list them). **PLEASE ADD PARENT NAME TO THIS LIST.**

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I hereby grant Lakewood Public Schools permission to photograph/video my child as they deem necessary for school use and/or public media release. YES / NO (please circle)

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements deemed necessary.

Allergies: _____

Do any of the above allergies require use of an Epi-Pen if exposed to or ingested? YES / NO (circle one), if yes please see the office.

Other Conditions: _____

Medications: _____

Primary Care Physician: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Office Use Only Date Entered: _____

PERMISSION TO PLACE

IF YOUR STUDENT RECEIVED SPECIAL EDUCATION SERVICES PLEASE COMPLETE THE BOX BELOW

Student Name	**Birthdate**	**Grade**
Parent Guardian Name	**Phone #**	
Previous School District		

FOR OFFICE USE ONLY

First day of attendance: _____ Date of Parent Consultation: _____

Student Transferred from: Inside County Out of County Out of State

Use the Current IEP from the previous school district: Y N

Current IEP date: _____ Date of Initial/Reeval IEP: _____

Primary Disability: _____

Program/Service	Amount of time & frequency	Actual hours	Teacher

Other options or factors considered?

_____

Why did you not select those services?

_____

_____ _____

Building Administrator Signature Date

Enrollment Form Questions for Identification of English Learners, Immigrant Students, and Migratory Students:

Home Language Survey Questions

Is your child's native (first) tongue a language other than English?

- Yes
- No

What is the other language? _____

¿Es el idioma nativo (primer idioma) de su hijo/hija otro aparte del inglés?

- Si
- No

¿Cuál es ese idioma? _____

Is the primary language used in your child's home or environment a language other than English

- Yes
- No

What is the other language? _____

¿Es el idioma principal usado en la casa o "barrio" de su hijo/hija un idioma diferente al inglés?

- Si
- No

¿Cuál es ese idioma? _____

Immigrant Student Identification

Where was your child/student born? State _____ Country _____

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

¿Dónde nació su hijo/hija/estudiante? Estado_____País_____

¿Si, su hijo/hija/estudiante nació en un país diferente a Estados Unidos, cuando fue que su hijo/hija/estudiante llego a Estados Unidos?_____

Migratory Student Identification

Have you or a family member worked in agriculture, poultry, dairy, and/or packing house in the last 3 years or 36 months?

- Yes
- No

  If yes, where did you work?_____Date:_____

¿A usted o alguien en su familia trabajado en agricultura, una lechería, o con animales como pollos o cerdos en los últimos 3 años?

Si, su respuesta es sí. Cuando _____ y Donde _____

Medicaid Annual Notification Regarding Parental Consent

Background:

Since 1993, the State of Michigan has participated in a Federal program called Medicaid School-Based Services. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Although this partial reimbursement is available only for students who are Medicaid eligible, services are provided to all students with disabilities regardless of their Medicaid eligibility status.

The Michigan School-Based Services program is under the direction of the Michigan Department of Community Health.

In 2013, the regulations regarding Medicaid parental consent for School-Based Services changed. Prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification. So what does all this mean?

Is there a cost to you?

NO – IEP/IFSP services are provided to students while they are at school at NO cost to the parent/guardian.

Will School-Based Medicaid claiming impact your family's Medicaid benefits?

The School-Based Services program does NOT impact a family's Medicaid services, funds, or limits. Michigan operates the School-Based Services program differently than the family's Medicaid program. The School-Based Services program does not affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?

- Evaluations
- Speech & Language/Audiology
- Occupational Therapy
- Physical Therapy
- Psychological/Social Work
- Orientation & Mobility
- Assistive Technology Svcs.
- Nursing
- Case Management
- Personal Care
- Special Education Transportation

What type of information about your child will be shared?

In order to submit claims for School-Based Services reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?

Information about your child's School-Based Services may be shared with the Michigan Medicaid agency and its affiliates for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?

You have the right to withdraw consent to disclose your child's personally identifiable information to the Michigan Medicaid agency and its affiliates at any time.

Will your consent or refusal affect your child's services?

NO. Regardless of whether you have Medicaid coverage or not (and whether you provide consent or not) the school district will still provide services to your child pursuant to their IEP or IFSP.

What if you have questions?

Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

Consent for Medicaid School-Based Services

Student Name:_____ Birth Date:_____

School District:_____

The Medicaid School-Based Services Program in Michigan:

- Provides partial reimbursement to school districts for services such as Occupational Therapy, Physical Therapy, Speech Therapy, Psychological Services, Social Work, Orientation and Mobility, Transportation, Nursing, Case Management and Assistive Technology Services.
- Does NOT affect a family's Medicaid insurance benefits and there is NO cost to the family, now or in the future.
- Helps school districts to offset some of the costs of health care provided to children.
- Is voluntary and requires a parent or guardian to provide written consent to release information about their child to the Michigan Medicaid agency and its affiliates to obtain reimbursement. This may include name, address, date of birth, student ID, Medicaid ID, disability, dates and services delivered.

If your child receives any of the services listed above and qualifies for Medicaid benefits at any time during the school year, we request your permission to release information to enable your school district to access School-Based Medicaid Reimbursement. The consent remains in effect from the beginning of the current school year until it is withdrawn. You have the right to withdraw this consent at any time by notifying your school district in writing. If you do not provide consent, the district will still provide the services at no cost to you.

By signing below, I understand and agree that _____and its local districts may access my child's public benefits or insurance information in order to seek reimbursement for services rendered as listed on the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

I have also received a copy of the Medicaid Annual Notification Regarding Parental Consent.

DATE: _____

Signature of Parent/Guardian: _____

LAKEWOOD PUBLIC SCHOOLS
Preparing our students for success.

August 2023

RE: Student Safety "Drop Off Locations"

To: Parents and Guardians of Lakewood Elementary Students
It is preferred that each of our students have the same end of the day routine. (ie. They get on the bus everyday) If your family is requesting to have multiple end of the day routines, please fill in below. (Possible reasons for choosing this option- custody, employment responsibilities, etc.)

Student:_____
Teacher:_____

Monday : ☐ My child will be walking home/sitter after school
☐ I will pick my child up after school
☐ My child will ride_____'s bus (Animal Name:_____)
to this address:_____

Tuesday: ☐ My child will be walking home/sitter after school
☐ I will pick my child up after school
☐ My child will ride_____'s bus (Animal Name:_____)
to this address:_____

Wed: ☐ My child will be walking home/sitter after school
☐ I will pick my child up after school
☐ My child will ride_____'s bus (Animal Name:_____)
to this address:_____

Thurs: ☐ My child will be walking home/sitter after school
☐ I will pick my child up after school
☐ My child will ride_____'s bus (Animal Name:_____)
to this address:_____

Friday : ☐ My child will be walking home/sitter after school
☐ I will pick my child up after school
☐ My child will ride_____'s bus (Animal Name:_____)
to this address:_____

_____ _____
Parent Signature Date

LAKEWOOD PUBLIC SCHOOLS
223 West Broadway
Woodland, Michigan
48897 616.374.8043
www.lakewoodps.org

LAKEWOOD ELEMENTARY
812 Washington Blvd
Lake Odessa, MI 48849

KEITH CARPENTER, PRINCIPAL
Phone 616.374.8842
Fax 616.374.1499

Food Service

MICHIGAN Department of Education

Michigan Department of Education
Office of School Support Services

CACFP REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant.

1. School/Agency Name:	2. Site Name:	3. Site Telephone:
4. Name of Participant/Student:		5. Participant Age:
6. Name of Parent/Guardian:		7. Parent/Guardian Telephone:

8. Check One:

☐Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to instructions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. One of the following licensed medical professionals must sign this form: **licensed physician (MD or DO), physician's assistant (PA),** or **nurse practitioner (NP).**

☐Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP) or speech pathologist must sign this form.**

☐Participant *does not have a disability*, but is requesting a special accommodation for a **fluid milk substitute** that meets the USDA nutrient standards for non-dairy beverages offered as milk substitutes. Granting the request of a non-dairy milk substitute is at the discretion of the facility. **A licensed physician, physician's assistant, registered dietitian nutritionist, nurse practitioner, or parent/guardian may sign this form.**

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (*please describe in detail to ensure proper implementation- use extra pages as needed*)

12. Foods to be omitted and substitutions: (*please list specific foods to be omitted and suggested substitutions; you may attach a sheet with additional information as needed.*)

A. Food(s) To Be Omitted: **B. Suggested Substitution(s)**

_____

_____

13. Indicate Texture:

☐Regular ☐Chopped ☐Ground ☐Pureed

14. Adaptive Equipment:

15. Signature of Preparer:	16. Printed Name:	17. Telephone:	18. Date
19. Signature of Medical Authority:	20. Printed Name: (include credentials)	21. Telephone	22. Date

Michigan Department of Education
Office of School Support Services

REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS INSTRUCTIONS

1. **School/Agency Name:** Print the name of the school or agency that is providing the form to the parent.
2. **Site Name:** Print the name of the site where meals will be served (e.g., XYZ school, XYZ child care center, XYZ family day care home, etc.).
3. **Site Telephone:** The telephone number of site where meal will be served. See #2.
4. **Name of Participant/Student:** Print the name of the child or adult participant to whom the information pertains.
5. **Participant Age:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent/Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Parent/Guardian Telephone:** Print the telephone number of parent or guardian.
8. **Check One:** Check a box to indicate whether participant has a disability, does not have a disability or does not have a disability but is requesting special accommodation for fluid milk substitution.
9. **Disability or medical condition requiring a special meal or accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.).
10. **If participant has a disability, provide a brief description of participant's major life activity affected by the disability:** Describe how the physical or medical condition affects the participant. For example: "Allergy to peanuts causes a life-threatening reaction."
11. **Diet prescription and/or accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
12. **Food(s) to be omitted and suggested substitution(s):** List specific foods that must be omitted. For example, "exclude fluid milk." List specific foods to include in the diet. For example, "Nutritionally equivalent non-dairy beverage."
13. **Indicate texture:** Check a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. Examples may include: sippy cup, large handled spoon, wheel-chair accessible furniture, etc.
15. **Signature of Parent/Guardian:** Signature of parent/guardian requesting the accommodation.
16. **Printed Name:** Print name of parent/guardian completing form.
17. **Date:** Date parent/guardian signed form.
18. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
19. **Printed Name with Credentials:** Print name of medical authority, including credentials.
20. **Telephone:** Telephone number of medical authority.
21. **Date:** Date medical authority signed form.

Disability Definition: The Americans with Disabilities Act Amendment Act defines a "disability," in part, as a physical or mental impairment that substantially limits a major life activity or major bodily function of an individual. (For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008). More Information regarding the ADAAA, which expanded the definition of disability, see the Comparison of ADA and ADAAA sheet (http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf).

Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: USDA-Office of Assistant Secretary for Civil Rights (http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

LAKEWOOD PUBLIC 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 LAKEWOOD PUBLIC 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: _____

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. An athlete 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 or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.
2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most athletes 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.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

_____

STUDENT-ATHLETE NAME PRINTED

_____

STUDENT-ATHLETE NAME SIGNED

_____

DATE

_____

PARENT OR GUARDIAN NAME PRINTED

_____

PARENT OR GUARDIAN NAME SIGNED

_____

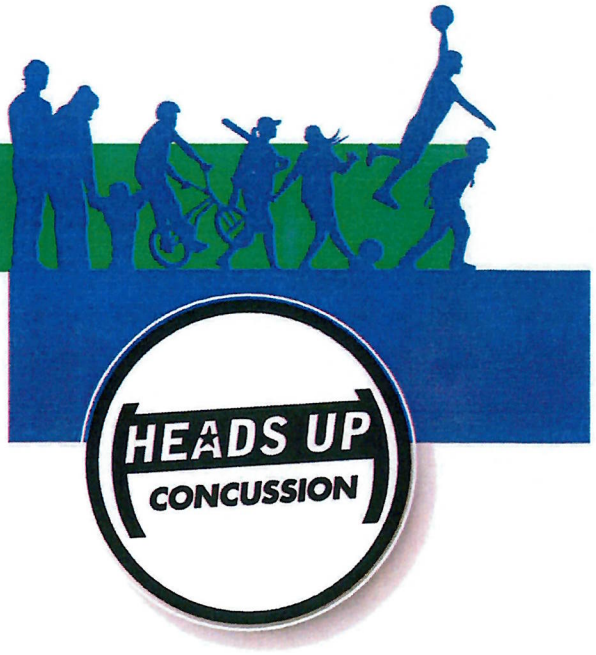
DATE

JOIN THE CONVERSATION ↳ www.facebook.com/CDCHeadsUp

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

PARENT & ATHLETE CONCUSSION INFORMATION SHEET



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 bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Michigan Department of Community Health
MDCH
Rick Snyder, Governor
James K. Haveman, Director

"IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON"

PLEASE REMOVE THIS PAGE, COMPLETE THE FORM AND RETURN TO SCHOOL

Student_____ **Grade**_____ **Teacher**_____

Acknowledgement of Handbook
I have received the handbook and acknowledge that I am aware of the following policies and procedures as outlined in the hand book.

Volunteer Driver Assurance
According to district policy 8600, when parents or adult's volunteers assist in the transportation of pupils, whether school-owned or private vehicles, the school district must reassure itself and the parents of the students involved that the drivers are over 21 years old, have a valid driver' license, are covered by insurance, have a good driving record, and will require that all occupants in the vehicle wear seat belts in accordance with Michigan law.

Your signature on page 24 verifies that you meet the following criteria as outlined in the policy.

- I am over the age of 21.
- I have a valid Michigan's driver's license
- I have no known medical condition which could cause me to have seizures or blackouts while driving.
- I have coverage by an insurance policy that is in force and has not expired.
- I have a driving record that is free of major moving violations.
- I will make certain that all student occupants in the vehicle wear seat belts in accordance with Michigan law.
- All safety features (brakes, horn, lights, and tires) on my vehicle are in good working order.

I understand that according to Michigan No-Fault law, my personal insurance would be the first to cover myself and the students that I am transporting. **Only if and when the limits of my personal insurance are exhausted would the school district's insurance provide coverage beyond my own.** My signature on this form indicates knowledge and acceptance of this fact.

If any of the situations above should change, I will notify the school before transporting students.

Computer/Internet/Technology Use Agreement

We have read the rules regarding Computer/Internet/Technology use in the handbook. The student signature indicates that the student agrees to abide by the rules established. The parent signature indicates an understanding that students will face disciplinary action for violating the rules.

Students are not allowed to use the computers until they agree to the rules. If there is a problem with those rules, please discuss them with the building principal.

Early Dismissal
Occasionally, it becomes necessary to close school early due to inclement weather or other unforeseen circumstances. In the event that this happens, the announcement will be posted on our web page as well as announced on WBCH and WION radio stations.

I would be interested in being part of the school community by:

____volunteering in the classroom
____sharing my knowledge about _____ in a classroom
____helping with classroom parties
____being an active member of the parents group
____being a mentor to a student in need
____volunteering to tutor students after school
____teaching an after school class about _____
____reading to a class of students
____talking about my job as a _____ to a classroom
____serving on a building improvement committee
____working on a school beautification work day

My and my student's signature below verifies the following:

- Acknowledgement of Handbook
- Release of Information
  _____Yes _____No
- Volunteer Driver Assurance
- Computer/Internet/Technology Use Agreement
- Permission to participate in intra district field trips and local points of interest (i.e. high school play, community library, park, etc.

_____
Name of Student

_____ _____
Student Signature Parent Phone Number

_____ _____
Parent Signature Parent Email Address

Please fill out the front and back of the back pack tag below. Please list your name and anyone that has permission to pick up your student.

STUDENT NAME

_____

Grade your student will be in for the 2022/2023 school year.

_____ 1st Grade

_____ 2nd Grade

_____ 3rd Grade

_____ 4th Grade

NAME **EVERYONE** THAT CAN PICK UP YOUR STUDENT **INCLUDING** Parents/Guardian

_____

_____

_____

_____

_____

_____

_____

_____

_____