YOU WILL NEED THE FOLLOWING PAPERWORK FOR ENROLLMENT:

1. BIRTH CERTIFICATE
2. SHOT RECORDS
3. SOCIAL SECURITY CARD
4. CUSTODY PAPERS
5. SPECIAL EDUCATION RECORDS
(if applicable)
6. TRANSCRIPT / LAST GRADE CARD
7. PROOF OF RESIDENCE

You may use the following documents for proof of residence –

1. A deed, mortgage, lease, current homeowner's or renter's insurance declaration page, or current real estate property tax bill
2. A utility bill or receipt of utility installation issued within ninety days of enrollment
3. A paycheck or paystub issued to the parent or student that includes the address of the parent's or student's primary residence
4. The most recent available bank statement issued to the parent or student that includes the address of the parent's or student's primary residence
5. Any other official document issued to the parent or student that includes the address of the parent's or student's primary residence. The superintendent of public instruction shall develop guidelines for determining what qualifies as an official document under this division

STUDENTS WILL NOT BE PERMITTED TO START SCHOOL UNTIL ALL PAPERWORK IS RECEIVED.

OHIO SCHOOL LAW

In order to facilitate the enforcement of the Missing Child Law, the law requires each entering student to provide, a certified copy of any child custody order or decree which has been issued with respect to the student. The custodial parent of such a student must also provide the school with certified copies of any later court orders which modify the original custody order or decree.

COSHOCTON OPPORTUNITY SCHOOL

Information supplied on this form is required under provisions of Ohio Law and the Ohio Department of Education.
It is in no way an effort to trespass upon the personal affairs of parents. Your cooperation in completing this form is appreciated.

PLEASE PRINT – PARENT/GUARDIAN SHOULD COMPLETE ALL INFORMATION.

1. STUDENT DATA

Grade student will be entering _____ Has student ever attended Coshocton Opp School? **Yes**___ **No**___ If YES: School _____ Grade(s) Enrolled _____

Student Name (LEGAL NAME AS IT APPEARS ON BIRTH CERTIFICATE):

_____ Last Name Suffix (Jr., III, etc)_____
First Middle Last

Gender (circle one)
F or **M**

Social Security #_____

County of Residence (circle one):

Home Phone: Area Code _____ --- _____ Unlisted? Yes___ No___

Coshocton

Street Address_____

Knox Holmes

P.O. Box #_____ City_____ Zip_____

Licking Muskingum

STUDENT'S BIRTH DATA

Date of Birth: Month_____ Day_____ Year_____ Mother's Maiden Name_____

Birth City_____ State _____If child was born outside U.S., list country_____

Citizenship of student: _____USA Other _____ (specify country)

Native Language spoken in home: ____English Other_____ (specify language)

If child was born outside the U.S., how many years has he/she been attending a U.S. school? _____

2. RACIAL / ETHNIC DATA

PLEASE ANSWER BOTH A AND B

A. Is the student Hispanic/Latino?
(Hispanic/Latino means a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

___ **Yes** ___ **No** (**go to part B**)

B. Is the student: **(check all that apply)**

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

___ **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.)

___ **Black or African American** (Persons having origins in any of the black racial groups in Africa.)

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

___ **White** (Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.)

(If left blank, ethnicity will be determined by observer identification)

Coshocton Opportunity School is mandated by the United States Department of Education, under the No Child Left Behind Act, to collect and report this information for all students who enroll in the school district.

3. PREVIOUS SCHOOL INFORMATION

- **Does your child have an IEP or 504 plan or has he/she received special education services in the past?**

  Yes___ **No**___
  (If yes, provide a current copy of IEP and ETR.)

- **Is student under expulsion from previous school?**

  Yes___ No___

- **School where child was most recently enrolled:**

District_____

School_____

School Address_____

Phone #_____

Fax # _____

PLEASE COMPLETE REVERSE SIDE →

PLEASE COMPLETE REVERSE SIDE →

COSHOCTON OPPORTUNITY SCHOOL REGISTRATION FORM

Information supplied on this form is required under provisions of Ohio Law and the Ohio Department of Education.
It is in no way an effort to trespass upon the personal affairs of parents. Your cooperation in completing this form is appreciated.

PLEASE PRINT – PARENT/GUARDIAN SHOULD COMPLETE ALL INFORMATION

Student Name_____ Grade_____

4. FAMILY & CUSTODIAL DATA

- **Status of Biological Parents:** ____Parents Married ____Parents never Married ____Parents Separated ____Parents Divorced ____Father Deceased ____Mother Deceased
- **Who has legal custody of this student?** _____

If a divorce or guardianship situation exists, we must have a certified full copy of the order of decree. This is per State of Ohio Law (ORC 3313.672) and the Missing Children's Act.

- **Student lives with:** ____Mother & Father ____Mother only ____Mother & Stepfather ____Father only ____Father & Stepmother ____Foster Parent ____Host parent ____Court appointed Guardians/Grandparents ____Other

INFORMATION for Mother /Guardian/ Foster Parent (circle one)

Name _____
First M.I. Last

Home address _____
Street Address City State Zip

Home Phone:_____ Cell Phone _____

Employer_____ Work phone_____

INFORMATION for Father /Guardian/ Foster Parent(circle one)

Name _____
First M.I. Last

Home address _____
Street Address City State Zip

Home Phone:_____ Cell Phone _____

Employer_____ Work phone_____

INFORMATION for Step-Mother /Step-Father (circle one)

Name _____
First M.I. Last

Home address _____
Street Address City State Zip

Home Phone:_____ Cell Phone _____

Employer_____ Work phone_____

Why do you want to attend Coshocton Opportunity School?

_____

_____

_____

_____

_____

_____

_____

OFFICE STAFF

HAVE YOU COLLECTED?

Legal Birth Certificate	Y	N
Proof of Residency	Y	N
Immunization Record	Y	N
Social Security Card	Y	N
Legal Custody Documents	Y	N
Court/Foster Placement Form	Y	N
Copy of IEP, if applicable	Y	N

5. PARENT / GUARDIAN SIGNATURE

I, the undersigned, state that I am the parent or legal guardian of the above named student and that the registration information provided is true and correct.

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

COSHOCTON OPPORTUNITY SCHOOL
EMERGENCY MEDICAL AUTHORIZATION

Student Name: _____ Telephone #: _____

Student Address: _____
Street City State Zip

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name _____ Contact Phone # _____

Father's Name _____ Contact Phone # _____

Other Contact _____ Contact Phone # _____

Name of Relative Living Closest To You _____

Relationship _____ Contact Phone # _____

Address _____
Street City State Zip

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospitals to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

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 above-named doctor, or, in the event the designated preferred 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.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

_____

_____

Signature of Parent _____ Date _____

PART II – REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following actions:

_____

_____

Signature of Parent _____ Date _____

2021-2022 Coshocton Opportunity School – Household income

Part 1. ALL HOUSEHOLD MEMBERS

Names of all household members (First, Middle Initial, Last)	Name of school and grade level for each child/or indicate "NA" if child is not in school. School	Grade	Check if a foster child (legal responsibility of welfare agency or court) *If all children listed below are foster children, skip to Part 5 to sign this form.	Check if No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Part 2. BENEFITS: If any member of your household receives Supplemental Nutrition Assistance Program (SNAP) or Ohio Works First (OWF) benefits, provide the name and 7-digit case number for the person who receives benefits and **skip to Part 5**. If no one receives these benefits, **skip to Part 3**.

NAME: ______________________ 7-DIGIT CASE NUMBER: ______________________

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [SCHOOL, HOMELESS LIAISON, or MIGRANT COORDINATOR] at [EMAIL] or [PHONE NUMBER].

Homeless ☐ Migrant ☐ Runaway ☐

Part 4. TOTAL HOUSEHOLD GROSS INCOME (before deductions). List all income on the same line as the person who receives it. Check the box for how often it is received. Record each income only once.

1. NAME (List all household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, Social Security, SSI, VA benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All Other Income (indicate frequency, such as "weekly" "monthly" "quarterly" "annually"
(Example) Jane Smith	$200	☒	☐	☐	☐	$150	☐	☒	☐	☐	$0	☐	☐	☐	☐	$50.00/ quarterly
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$____/____
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$____/____
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$____/____
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$____/____
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$____/____

Part 5. SCHOOL INSTRUCTIONAL FEE WAIVER ADULT CONSENT: Your child(ren) may qualify for a waiver of their school instructional fees. Your permission is required to share your meal application information with school officials to determine if your child(ren) qualifies for a fee waiver. Answering this question will not change whether your children will receive free or reduced-price meals.

Please check a box: ☐Yes, I agree to have my meal application used to determine if my child(ren) qualifies for a fee waiver.

☐ No, I do not agree to have my meal application used to determine if my child(ren) qualifies for a fee waiver.

Signature of Parent/Guardian: ______________________ Date: __________

Part 6. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box**. (See Privacy Act Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will receive federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that deliberate misrepresentation of the information may cause my children to lose meal benefits and I may be subject to prosecution under state and federal statutes.

Sign here: X______________________ Print name: ______________________ Date: __________

Address: ______________________ Phone Number: __________

Last four digits of your Social Security Number: _ _ _ _ ☐ I do not have a Social Security Number

Part 7. Children's ethnic and racial identities: We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced-price meals.

Choose one ethnicity:	Choose one or more (regardless of ethnicity):
☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Asian ☐American Indian or Alaska Native ☐ Black or African American ☐ White ☐Native Hawaiian or other Pacific Islander

ANNUAL MEDICAL UPDATE
2021-2022

STUDENT NAME | DATE OF BIRTH | BUILDING | GRADE & TEACHER

I. HEALTH CONDITIONS – Please, check any that this student has had: **DATE OF LAST EXAM: PHYSICAL** _____ **DENTAL** _____

_____Abnormal spinal curvature (scoliosis, etc.)
_____Allergies or hay fever (list below in section IV)
_____Anemia
_____Arthritis
_____Asthma
_____Behavior problems
_____Birth or congenital malformation
_____Cancer, Type_____
_____Chicken Pox
_____Concern about siblings/friend relationship
_____Cystic Fibrosis
_____Diabetes
_____Diarrhea, or Constipation
_____Eczema
_____Emotional Problems
_____Headaches (frequent)
_____Heart Disease
_____Hepatitis
_____Kidney Disease
_____Measles (10 day)
_____Meningitis or Encephalitis
_____Mumps
_____Rheumatic Fever
_____Rubella (3 day measles)
_____Seizures/epilepsy
_____Sickle Cell disease
_____Skin rashes (frequent)
_____Stool soiling
_____Throat infections (frequent)
_____Tics/nervous twitches
_____Tuberculosis or + TB
_____Urinary Tract Infections
_____Wetting (daytime/night)

Please comment, as you feel necessary, on any of the above (more space provided on back of page):_____

II. VISION AND HEARING

Frequent ear infections?_____Which ear?_____How often?_____
Reduction in hearing?_____When?_____ P.E. Tubes?_____In place?_____
Wears glasses/contacts (circle)? Reason? (circle) Distance Close-up Other-explain _____

III. INJURIES/ILLNESSES/SURGERIES– Please list any surgeries, severe injuries or illnesses:

Injuries/Illnesses/Surgery	Age	Hospitalized/Treatment

Comments (more space provided on back of page):_____

IV. ADDITIONAL INFORMATION

DAILY medication, dosage, condition being treated:	MEDICATION or ENVIRONMENTAL ALLERGIES:
Medications taken frequently but not daily & reason:	

Signing below gives your permission for the school nurse to contact your child's physician concerning any health care concerns and for this information to be shared with school staff as needed to care for your child during the 2015/2016 school year.

COMPLETED BY:_____ RELATIONSHIP TO STUDENT:_____DATE:_____

4/10/15

Please attach any other relevant medical information, if necessary. Addition comments concerning health issues, medications & concerns: _____

STUDENT – PARENT/GUARDIAN SIGNATURE FORM

HANDBOOK AND ALL POLICIES ARE AVAILABLE ON THE SCHOOL WEBSITE WWW.COSHOCTONOPPORTUNITYSCHOOL.COM

By signing below, I am verifying that I have received and read copies of the policies, rules and regulations referred to and that I give permission for my child to participate in the designated activities. Initial each item in agreement.

_____ _____ **ACKNOWLEDGE OF STUDENT HANDBOOK**
Parent Initials Student Initials
I have read and understand the Student Handbook.

_____ _____ **COMPUTER PRIVACY AND ACCEPTABLE USE POLICY**
Parent Initials Student Initials
I have read and agree to the Network Privacy and Acceptable Use Policy. I will repay the District for any fees, expense, or damages incurred as a result of my or my child's use or misuse of the Network or equipment.

_____ _____ **PERMISSION FOR PHOTOGRAPHY, VIDEOTAPING AND MEDIA PUBLISHING**
Parent Initials Student Initials
There are potential dangers associated with the posting of personally identifiable information on a website since global access to the Internet does not allow us to control who may access such information. These dangers have always existed, however Coshocton Opportunity School recognizes that the first priority is the safety and privacy of our students. To this end, the district will implement the following procedures:

- The district will not publish a student's last name, address, phone, age or written description on our website.
- Individual pictures will only be posted with first name and only if consent is granted above.
- Groups of students in photos will have no names attached.

_____ _____ **RIGHT TO SEARCH ARGEEMENT**
Parent Initials Student Initials
Any person or property (such as, but not limited to, backpacks, gym bags, lockers, band instrument cases, or any packages capable of concealing a weapon) may be searched with or without consent while under jurisdiction.

_____ _____ **SCHOOL PROPERTY AGREEMENT**
Parent Initials Student Initials
I will be financially responsible for any lost or damaged school property.

_____ _____ **USE OF TRAINED DOGS**
Parent Initials Student Initials
I understand that trained dogs may be used for blanket and individual searches.

Parent Initials _____ Student Initials _____

ZERO TOLERANCE PERTAINING TO DRUGS AND ALCOHOL

Coshocton Opportunity School prohibits the use, possession, concealment or distribution of any drug or any drug-related paraphernalia as the term as defined by law, on school grounds, on school vehicles, and at any school-sponsored events. The minimum punishment for violation of this policy will be one as per discipline section of the handbook.

Parent Initials _____ Student Initials _____

FERPA and DIRECTORY INFORMATION (Policy #***)**

I give permission to Coshocton Opportunity School to release directory information regarding my student. Directory information may include: student's name, address, telephone number, date and place of birth, major field of study, participation in activities and sports, height and weight if a member of an athletic teams, dates of attendance, date of graduation or awards received.

Parent Initials _____ Student Initials _____

GOVERNING AUTHORITY MEMBERS QUALIFICATONS POLICY NO. 1470

Parent Initials _____ Student Initials _____

SCHOOL ASSET POLICY POLICY NO. 1753

Parent Initials _____ Student Initials _____

PROCUREMENT OF EPINEPHRINE AUTO-INJECTORS BY SCHOOLS POLICY NO. 2241

Parent Initials _____ Student Initials _____

DIABETIC CARE POLICY NO. 2270

Parent Initials _____ Student Initials _____

ADMINISTRATION OF NALOXONE POLICY NO. 2460

Parent Initials _____ Student Initials _____

ENVIRONMENTAL SAFTEY POLICIES NO. 2500

Parent Initials _____ Student Initials _____

CRISIS MANAGEMENT AND RESPONSE PLAN POLICY NO. 2630

Parent Initials _____ Student Initials _____

ADMISSION PROCEDURE POLICY NO. 3511

Parent Initials _____ Student Initials _____

KINDERGARTEN AND FIRST GRADE ADMISSION POLICY NO. 3512

Parent Initials _____ Student Initials _____

COLLEGE CREDIT PLUS POLICY NO. 3670

Parent Initials	Student Initials	**CAREER ADVISING** **POLICY NO. 3680**
Parent Initials	Student Initials	**INDEPENDENT EDUCATIONAL EVALUATION** **POLICY NO. 3710.2**
Parent Initials	Student Initials	**STUDENT RECORDS AND RELEASE OF INFORMATION** **POLICY NO. 3831** **FORM NO. 3831.1**
Parent Initials	Student Initials	**TRACKING MISSING CHILDREN** **POLICY NO. 3833**
Parent Initials	Student Initials	**STUDENT FINGERPRINTING** **POLICY NO. 6140**

Student's Signature	**Student's Printed Name**	**Date**
Parent/Guardian's Signature	**Parent/Guardian's Printed Name**	**Date**

Care Team Collaborative

(including Personally Identifiable Information), Medical Records (including Protected Health Information), and Records Pertaining to Drug and Alcohol Treatment Programs

This form is designed to be used by school districts and other organizations that collaborate with the Muskingum Valley Educational Service Center and its Care Team Collaborative in planning, coordinating, and delivering services to CTC children and families. This form addresses release, use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, and payment for services and program operations. This form complies with the requirements of Sections 3319.321 and 3793.13 of the Ohio Revised Code regarding education and drug and alcohol program records, federal requirements for disclosure of alcohol and drug records (42 CFR Part 2), Protected Health Information under HIPAA (45 C.F.R. Parts 160 and 164), and education records (34 CFR Part 99).

Dear Parent/Guardian:

Our school participates in Muskingum Valley Educational Service Center's Care Team Collaborative (CTC). We have developed a strong relationship between our school and the community partners who provide Care Team related services. In order to plan and provide services to your child, we may need to share information with CTC community partners regarding your child's education records, medical records and/or records pertaining to drug or alcohol treatment programs.

By completing this form, you authorize and permit us to release your child's education records to the CTC. You also authorize the CTC to share its records regarding your child, including education records, with CTC members and partners, as may be needed to provide services.

By completing this form, you also authorize and direct any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to your child to disclose and release medical records, including any and all protected health information in its possession, to the Muskingum Valley Educational Service Center and its Care Team Collaborative. You also authorize the CTC to share these records with CTC members and partners. **Medical records will be obtained and shared by CTC only as needed to plan and provide services to your child.**

You may request a copy of any records that are disclosed pursuant to this authorization. The CTC will maintain a record of each disclosure of personally identifiable information from your child's records. This record will be maintained with your child's education records as long as these records are maintained by the CTC. The CTC will maintain a record of each time it shares personally identifiable information from your child's records with CTC members and providers.

You may withdraw this consent at any time by giving written notice to the CTC and to your child's school district, and to any health care and/or drug and alcohol treatment providers subject to this consent. However, withdrawal of consent will apply only to information exchanges after the withdrawal is received.

Coshocton County Use Only

Care Team Collaborative

Attachment A

This authorization for disclosure, receipt and re-disclosure of records may apply to the following organizations and people who work at those organizations. These organizations work together to deliver services to students participating in Muskingum Valley Educational Service Center's Care Team Collaborative.

Coshocton County Department of Job & Family Services	Six County, Inc.
Coshocton County Health Department	Coshocton City Health Department
Coshocton County Board of MR/DD	Coshocton City Schools
Mental Health & Recovery Services	Big Brothers/ Big Sisters
Department of Youth Services	Coshocton County Juvenile Court
Thompkins Child & Adolescent Services	Coshocton County Family & Children First Council
Coshocton Behavioral Health Services	Help Me Grow
Family PACT	First Step Family Intervention Services
Coshocton County WIC	Coshocton County GRADS
Muskingum Valley Educational Service Center	Care Team Collaborative
Art Therapy	JOG
Ed & Chris Gallagher	**Other: (Please list below.)**

I hereby give permission to obtain, use, and re-disclose health, alcohol and drug, and education records as described below.

1. **The child whose information may be used or disclosed is:**

Name:_____ Date of Birth: _____Soc. Sec. #___-___-____

2. **The information that may be used or disclosed includes (initial all that apply):**
   - _____Education Records
   - _____Health Records, including Protected Health Information
   - _____Alcohol or Drug Treatment Records
   - _____All of the records listed

3. **This information may be disclosed by (initial all that apply):**
   - _____Any person or organization possessing the information to be disclosed
   - _____The following persons or organizations who provide services to my child (list below):
   - _____The persons or organizations listed in Attachment A

   _____

4. **This information may be disclosed to (initial all that apply):**
   - _____ Any person, organization that needs the information to provide services to my child, pay for those services, engage in quality assurance or other health care operations related to that person
   - _____The following persons or organizations (list below):
   - _____The persons or organizations listed in Attachment A

   _____

5. **The purposes for which this information may be used and disclosed include:**

- Evaluation of eligibility to participate in programs supported by or available through the Muskingum Valley Educational Service Center Care Team Collaborative or its member agencies, service providers, and/or school districts;
- Delivery of services, including care coordination and case management;
- Payment for services; and
- Other administrative and operational purposes, such as quality assurance.

6. **This authorization expires 30 calendar days after the start of the next school year unless marked below. (Only mark if you want a DIFFERENT expiration date)**
   - ☐ Expires on this date: _____
   - ☐ Permission only applies for the following time period: From (date)_____ to (date)_____
   - ☐ Other limitation: Explain.

_____

Care Team Collaborative

7. CTC has permission to use my child's photograph for purposes related to informing others about CTC programs and services. I understand my child's name or other personally identifiable information will not be associated with photographs without my express permission.
   ☐ Yes ☐ No

8. I understand that I may revoke this permission. I understand that if this permission is revoked, it may not be possible for my child to continue to participate in certain programs or receive certain services. I may be informed of that possibility if I wish to revoke this permission. I understand records disclosed before this permission is revoked may not be retrieved, and any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work begun because this permission was given.

9. I understand that federal and state law permit health, alcohol or drug abuse records possessed by a school and properly deemed to be educational records to be re-disclosed without the consent of a parent or guardian to schools and other entities authorized to receive educational records, when such re-disclosure is for reasons authorized by law.

10. I understand that Ohio and federal law generally prohibit persons receiving health, alcohol or drug abuse records from re-disclosing those records without permission. I understand that not every organization that may receive health records is required to follow federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORDS AND THE INFORMATION IN THE RECORDS TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 4 FOR THE PURPOSES PERMITTED IN PARAGRAPH 5, BUT FOR NO OTHER PURPOSE.

Parent/Guardian Name (Print)	Parent/Guardian Signature	Date
Student Name (Print)	Student Signature	Date

See Attachment A for list of partners supporting Care Team in my school district.

REFUSAL TO CONSENT

My student, _____, has been offered Care Team Collaborative services and supports. I refuse consent at this time. I understand that my refusal may result in further lack of school success, possibly leading to out of school suspension, court involvement and/or failure to graduate.

Parent/Guardian Name (Print)	Parent/Guardian Signature	Date
Student Name (Print)	Student Signature	Date

COSHOCTON OPPORTUNITY SCHOOL

Information supplied on this form is required under provisions of Ohio Law and the Ohio Department of Education.
It is in no way an effort to trespass upon the personal affairs of parents. Your cooperation in completing this form is appreciated.

PLEASE PRINT – PARENT/GUARDIAN SHOULD COMPLETE ALL INFORMATION.

1. STUDENT DATA

Grade student will be entering _____

Has student ever attended Coshocton Opp School?
Yes____ **No**____ If YES: School _____
Grade(s) Enrolled_____

Student Name (LEGAL NAME AS IT APPEARS ON BIRTH CERTIFICATE):

_____ Last Name Suffix (Jr., III, etc)_____
First Middle Last

Gender (circle one)
F or **M**

Social Security #_____

County of Residence (circle one):

Home Phone: Area Code _____ --- _____ Unlisted? Yes___ No___

Coshocton
Knox Holmes
Licking Muskingum

Street Address_____

P.O. Box #_____ City_____ Zip_____

STUDENT'S BIRTH DATA

Date of Birth: Month_____ Day_____ Year_____ Mother's Maiden Name_____

Birth City_____ State _____If child was born outside U.S., list country_____

Citizenship of student: ____USA Other _____ (specify country)

Native Language spoken in home: ____English Other_____ (specify language)

If child was born outside the U.S., how many years has he/she been attending a U.S. school? _____

2. RACIAL / ETHNIC DATA

PLEASE ANSWER BOTH A AND B

A. Is the student Hispanic/Latino?
(Hispanic/Latino means a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

___ **Yes** ___ **No** (**go to part B**)

B. Is the student: **(check all that apply)**

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

___ **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.)

___ **Black or African American** (Persons having origins in any of the black racial groups in Africa.)

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

___ **White** (Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.)

(If left blank, ethnicity will be determined by observer identification)

Coshocton Opportunity School is mandated by the United States Department of Education, under the No Child Left Behind Act, to collect and report this information for all students who enroll in the school district.

3. PREVIOUS SCHOOL INFORMATION

- **Does your child have an IEP or 504 plan or has he/she received special education services in the past?**

  Yes___ **No**___
  (If yes, provide a current copy of IEP and ETR.)

- **Is student under expulsion from previous school?**

  Yes___ No___

- **School where child was most recently enrolled:**

District_____

School_____

School Address_____

Phone #_____

Fax # _____

PLEASE COMPLETE REVERSE SIDE →

PLEASE COMPLETE REVERSE SIDE →

Rev. 04/2010

COSHOCTON OPPORTUNITY SCHOOL REGISTRATION FORM

Information supplied on this form is required under provisions of Ohio Law and the Ohio Department of Education.
It is in no way an effort to trespass upon the personal affairs of parents. Your cooperation in completing this form is appreciated.

PLEASE PRINT – PARENT/GUARDIAN SHOULD COMPLETE ALL INFORMATION

Student Name_____ Grade_____

4. FAMILY & CUSTODIAL DATA

- **Status of Biological Parents:** _____Parents Married _____Parents never Married _____Parents Separated _____Parents Divorced _____Father Deceased _____Mother Deceased
- **Who has legal custody of this student?** _____

If a divorce or guardianship situation exists, we must have a certified full copy of the order of decree. This is per State of Ohio Law (ORC 3313.672) and the Missing Children's Act.

- **Student lives with:** _____ Mother & Father _____ Mother only _____Mother & Stepfather _____ Father only _____ Father & Stepmother _____Foster Parent _____Host parent _____Court appointed Guardians/Grandparents _____ Other

INFORMATION for Mother /Guardian/ Foster Parent (circle one)

Name _____
First M.I. Last

Home address _____
Street Address City State Zip

Home Phone:_____Cell Phone _____

Employer_____ Work phone_____

INFORMATION for Father /Guardian/ Foster Parent(circle one)

Name _____
First M.I. Last

Home address _____
Street Address City State Zip

Home Phone:_____Cell Phone _____

Employer_____ Work phone_____

INFORMATION for Step-Mother /Step-Father (circle one)

Name _____
First M.I. Last

Home address _____
Street Address City State Zip

Home Phone:_____Cell Phone _____

Employer_____ Work phone_____

Why do you want to attend Coshocton Opportunity School?

_____

_____

_____

_____

_____

_____

_____

OFFICE STAFF

HAVE YOU COLLECTED?

Legal Birth Certificate	Y	N
Proof of Residency	Y	N
Immunization Record	Y	N
Social Security Card	Y	N
Legal Custody Documents	Y	N
Court/Foster Placement Form	Y	N
Copy of IEP, if applicable	Y	N

5. PARENT / GUARDIAN SIGNATURE

I, the undersigned, state that I am the parent or legal guardian of the above named student and that the registration information provided is true and correct.

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

COSHOCTON OPPORTUNITY SCHOOL
EMERGENCY MEDICAL AUTHORIZATION

Student Name: _____ Telephone #: _____

Student Address: _____
Street City State Zip

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name _____ Contact Phone # _____

Father's Name _____ Contact Phone # _____

Other Contact _____ Contact Phone # _____

Name of Relative Living Closest To You _____

Relationship _____ Contact Phone # _____

Address _____
Street City State Zip

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospitals to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

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 above-named doctor, or, in the event the designated preferred 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.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

_____

_____

Signature of Parent _____ Date _____

PART II – REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following actions:

_____

_____

Signature of Parent _____ Date _____

2021-2022 Coshocton Opportunity School – Household income

Part 1. ALL HOUSEHOLD MEMBERS

Names of all household members (First, Middle Initial, Last)	Name of school and grade level for each child/or indicate "NA" if child is not in school. School	Grade	Check if a foster child (legal responsibility of welfare agency or court) *If all children listed below are foster children, skip to Part 5 to sign this form.	Check if No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Part 2. BENEFITS: If any member of your household receives Supplemental Nutrition Assistance Program (SNAP) or Ohio Works First (OWF) benefits, provide the name and 7-digit case number for the person who receives benefits and **skip to Part 5**. If no one receives these benefits, **skip to Part 3**.

NAME: ______________________ 7-DIGIT CASE NUMBER: ______________________

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call [SCHOOL, HOMELESS LIAISON, or MIGRANT COORDINATOR] at [EMAIL] or [PHONE NUMBER].

Homeless ☐ Migrant ☐ Runaway ☐

Part 4. TOTAL HOUSEHOLD GROSS INCOME (before deductions). List all income on the same line as the person who receives it. Check the box for how often it is received. Record each income only once.

1. NAME (List all household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED															
	Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, Social Security, SSI, VA benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All Other Income (indicate frequency, such as "weekly" "monthly" "quarterly" "annually"
(Example) Jane Smith	$200	☒	☐	☐	☐	$150	☐	☒	☐	☐	$0	☐	☐	☐	☐	$50.00/ quarterly
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$______/______
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$______/______
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$______/______
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$______/______
	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$______/______

Part 5. SCHOOL INSTRUCTIONAL FEE WAIVER ADULT CONSENT: Your child(ren) may qualify for a waiver of their school instructional fees. Your permission is required to share your meal application information with school officials to determine if your child(ren) qualifies for a fee waiver. Answering this question will not change whether your children will receive free or reduced-price meals.

Please check a box: ☐Yes, I agree to have my meal application used to determine if my child(ren) qualifies for a fee waiver.

☐ No, I do not agree to have my meal application used to determine if my child(ren) qualifies for a fee waiver.

Signature of Parent/Guardian: ______________________________ Date: ______________

Part 6. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box**. (See Privacy Act Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will receive federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that deliberate misrepresentation of the information may cause my children to lose meal benefits and I may be subject to prosecution under state and federal statutes.

Sign here: X______________________________ Print name: ______________________________ Date: ______________

Address: ____ Phone Number: ______________________

Last four digits of your Social Security Number: _ _ _ _ ☐ I do not have a Social Security Number

Part 7. Children's ethnic and racial identities: We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced-price meals.

Choose one ethnicity:	Choose one or more (regardless of ethnicity):
☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Asian ☐American Indian or Alaska Native ☐ Black or African American ☐ White ☐Native Hawaiian or other Pacific Islander

ANNUAL MEDICAL UPDATE
2021-2022

STUDENT NAME DATE OF BIRTH BUILDING GRADE & TEACHER

I. HEALTH CONDITIONS – Please, check any that this student has had: **DATE OF LAST EXAM: PHYSICAL** _____ **DENTAL** _____

_____Abnormal spinal curvature (scoliosis, etc.)
_____Allergies or hay fever (list below in section IV)
_____Anemia
_____Arthritis
_____Asthma
_____Behavior problems
_____Birth or congenital malformation
_____Cancer, Type_____
_____Chicken Pox
_____Concern about siblings/friend relationship
_____Cystic Fibrosis
_____Diabetes
_____Diarrhea, or Constipation
_____Eczema
_____Emotional Problems
_____Headaches (frequent)
_____Heart Disease
_____Hepatitis
_____Kidney Disease
_____Measles (10 day)
_____Meningitis or Encephalitis
_____Mumps
_____Rheumatic Fever
_____Rubella (3 day measles)
_____Seizures/epilepsy
_____Sickle Cell disease
_____Skin rashes (frequent)
_____Stool soiling
_____Throat infections (frequent)
_____Tics/nervous twitches
_____Tuberculosis or + TB
_____Urinary Tract Infections
_____Wetting (daytime/night)

Please comment, as you feel necessary, on any of the above (more space provided on back of page):_____

II. VISION AND HEARING

Frequent ear infections?_____Which ear?_____How often?_____
Reduction in hearing?_____When?_____ P.E. Tubes?_____In place?_____
Wears glasses/contacts (circle)? Reason? (circle) Distance Close-up Other-explain _____

III. INJURIES/ILLNESSES/SURGERIES– Please list any surgeries, severe injuries or illnesses:

Injuries/Illnesses/Surgery	Age	Hospitalized/Treatment

Comments (more space provided on back of page):_____

IV. ADDITIONAL INFORMATION

DAILY medication, dosage, condition being treated:	MEDICATION or ENVIRONMENTAL ALLERGIES:
Medications taken frequently but not daily & reason:	

Signing below gives your permission for the school nurse to contact your child's physician concerning any health care concerns and for this information to be shared with school staff as needed to care for your child during the 2015/2016 school year.

COMPLETED BY:_____ RELATIONSHIP TO STUDENT:_____DATE:_____

4/10/15

Please attach any other relevant medical information, if necessary. Addition comments concerning health issues, medications & concerns: _____

STUDENT – PARENT/GUARDIAN SIGNATURE FORM

HANDBOOK AND ALL POLICIES ARE AVAILABLE ON THE SCHOOL WEBSITE WWW.COSHOCTONOPPORTUNITYSCHOOL.COM

By signing below, I am verifying that I have received and read copies of the policies, rules and regulations referred to and that I give permission for my child to participate in the designated activities. Initial each item in agreement.

ACKNOWLEDGE OF STUDENT HANDBOOK

_____ _____
Parent Initials Student Initials

I have read and understand the Student Handbook.

COMPUTER PRIVACY AND ACCEPTABLE USE POLICY

_____ _____
Parent Initials Student Initials

I have read and agree to the Network Privacy and Acceptable Use Policy. I will repay the District for any fees, expense, or damages incurred as a result of my or my child's use or misuse of the Network or equipment.

PERMISSION FOR PHOTOGRAPHY, VIDEOTAPING AND MEDIA PUBLISHING

_____ _____
Parent Initials Student Initials

There are potential dangers associated with the posting of personally identifiable information on a website since global access to the Internet does not allow us to control who may access such information. These dangers have always existed, however Coshocton Opportunity School recognizes that the first priority is the safety and privacy of our students. To this end, the district will implement the following procedures:

- The district will not publish a student's last name, address, phone, age or written description on our website.
- Individual pictures will only be posted with first name and only if consent is granted above.
- Groups of students in photos will have no names attached.

RIGHT TO SEARCH ARGEEMENT

_____ _____
Parent Initials Student Initials

Any person or property (such as, but not limited to, backpacks, gym bags, lockers, band instrument cases, or any packages capable of concealing a weapon) may be searched with or without consent while under jurisdiction.

SCHOOL PROPERTY AGREEMENT

_____ _____
Parent Initials Student Initials

I will be financially responsible for any lost or damaged school property.

USE OF TRAINED DOGS

_____ _____
Parent Initials Student Initials

I understand that trained dogs may be used for blanket and individual searches.

Parent Initials _____ Student Initials _____

ZERO TOLERANCE PERTAINING TO DRUGS AND ALCOHOL

Coshocton Opportunity School prohibits the use, possession, concealment or distribution of any drug or any drug-related paraphernalia as the term as defined by law, on school grounds, on school vehicles, and at any school-sponsored events. The minimum punishment for violation of this policy will be one as per discipline section of the handbook.

Parent Initials _____ Student Initials _____

FERPA and DIRECTORY INFORMATION (Policy #***)**

I give permission to Coshocton Opportunity School to release directory information regarding my student. Directory information may include: student's name, address, telephone number, date and place of birth, major field of study, participation in activities and sports, height and weight if a member of an athletic teams, dates of attendance, date of graduation or awards received.

Parent Initials _____ Student Initials _____

GOVERNING AUTHORITY MEMBERS QUALIFICATONS POLICY NO. 1470

Parent Initials _____ Student Initials _____

SCHOOL ASSET POLICY POLICY NO. 1753

Parent Initials _____ Student Initials _____

PROCUREMENT OF EPINEPHRINE AUTO-INJECTORS BY SCHOOLS POLICY NO. 2241

Parent Initials _____ Student Initials _____

DIABETIC CARE POLICY NO. 2270

Parent Initials _____ Student Initials _____

ADMINISTRATION OF NALOXONE POLICY NO. 2460

Parent Initials _____ Student Initials _____

ENVIRONMENTAL SAFTEY POLICIES NO. 2500

Parent Initials _____ Student Initials _____

CRISIS MANAGEMENT AND RESPONSE PLAN POLICY NO. 2630

Parent Initials _____ Student Initials _____

ADMISSION PROCEDURE POLICY NO. 3511

Parent Initials _____ Student Initials _____

KINDERGARTEN AND FIRST GRADE ADMISSION POLICY NO. 3512

Parent Initials _____ Student Initials _____

COLLEGE CREDIT PLUS POLICY NO. 3670

Parent Initials	Student Initials	**CAREER ADVISING** **POLICY NO. 3680**
Parent Initials	Student Initials	**INDEPENDENT EDUCATIONAL EVALUATION** **POLICY NO. 3710.2**
Parent Initials	Student Initials	**STUDENT RECORDS AND RELEASE OF INFORMATION** **POLICY NO. 3831** **FORM NO. 3831.1**
Parent Initials	Student Initials	**TRACKING MISSING CHILDREN** **POLICY NO. 3833**
Parent Initials	Student Initials	**STUDENT FINGERPRINTING** **POLICY NO. 6140**

Student's Signature	**Student's Printed Name**	**Date**
Parent/Guardian's Signature	**Parent/Guardian's Printed Name**	**Date**

Care Team Collaborative

(including Personally Identifiable Information),
Medical Records (including Protected Health Information), and
Records Pertaining to Drug and Alcohol Treatment Programs

This form is designed to be used by school districts and other organizations that collaborate with the Muskingum Valley Educational Service Center and its Care Team Collaborative in planning, coordinating, and delivering services to CTC children and families. This form addresses release, use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, and payment for services and program operations. This form complies with the requirements of Sections 3319.321 and 3793.13 of the Ohio Revised Code regarding education and drug and alcohol program records, federal requirements for disclosure of alcohol and drug records (42 CFR Part 2), Protected Health Information under HIPAA (45 C.F.R. Parts 160 and 164), and education records (34 CFR Part 99).

Dear Parent/Guardian:

Our school participates in Muskingum Valley Educational Service Center's Care Team Collaborative (CTC). We have developed a strong relationship between our school and the community partners who provide Care Team related services. In order to plan and provide services to your child, we may need to share information with CTC community partners regarding your child's education records, medical records and/or records pertaining to drug or alcohol treatment programs.

By completing this form, you authorize and permit us to release your child's education records to the CTC. You also authorize the CTC to share its records regarding your child, including education records, with CTC members and partners, as may be needed to provide services.

By completing this form, you also authorize and direct any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to your child to disclose and release medical records, including any and all protected health information in its possession, to the Muskingum Valley Educational Service Center and its Care Team Collaborative. You also authorize the CTC to share these records with CTC members and partners. **Medical records will be obtained and shared by CTC only as needed to plan and provide services to your child.**

You may request a copy of any records that are disclosed pursuant to this authorization. The CTC will maintain a record of each disclosure of personally identifiable information from your child's records. This record will be maintained with your child's education records as long as these records are maintained by the CTC. The CTC will maintain a record of each time it shares personally identifiable information from your child's records with CTC members and providers.

You may withdraw this consent at any time by giving written notice to the CTC and to your child's school district, and to any health care and/or drug and alcohol treatment providers subject to this consent. However, withdrawal of consent will apply only to information exchanges after the withdrawal is received.

Coshocton County Use Only

Care Team Collaborative

Attachment A

This authorization for disclosure, receipt and re-disclosure of records may apply to the following organizations and people who work at those organizations. These organizations work together to deliver services to students participating in Muskingum Valley Educational Service Center's Care Team Collaborative.

Coshocton County Department of Job & Family Services	Six County, Inc.
Coshocton County Health Department	Coshocton City Health Department
Coshocton County Board of MR/DD	Coshocton City Schools
Mental Health & Recovery Services	Big Brothers/ Big Sisters
Department of Youth Services	Coshocton County Juvenile Court
Thompkins Child & Adolescent Services	Coshocton County Family & Children First Council
Coshocton Behavioral Health Services	Help Me Grow
Family PACT	First Step Family Intervention Services
Coshocton County WIC	Coshocton County GRADS
Muskingum Valley Educational Service Center	Care Team Collaborative
Art Therapy	JOG
Ed & Chris Gallagher	**Other: (Please list below.)**

I hereby give permission to obtain, use, and re-disclose health, alcohol and drug, and education records as described below.

1. **The child whose information may be used or disclosed is:**

Name:_____ Date of Birth: _____Soc. Sec. #___-___-____

2. **The information that may be used or disclosed includes (initial all that apply):**
   _____Education Records
   _____Health Records, including Protected Health Information
   _____Alcohol or Drug Treatment Records
   _____All of the records listed

3. **This information may be disclosed by (initial all that apply):**
   _____Any person or organization possessing the information to be disclosed
   _____The following persons or organizations who provide services to my child (list below):
   _____The persons or organizations listed in Attachment A

   _____

4. **This information may be disclosed to (initial all that apply):**
   _____ Any person, organization that needs the information to provide services to my child, pay for those services, engage in quality assurance or other health care operations related to that person
   _____The following persons or organizations (list below):
   _____The persons or organizations listed in Attachment A

   _____

5. **The purposes for which this information may be used and disclosed include:**

- Evaluation of eligibility to participate in programs supported by or available through the Muskingum Valley Educational Service Center Care Team Collaborative or its member agencies, service providers, and/or school districts;
- Delivery of services, including care coordination and case management;
- Payment for services; and
- Other administrative and operational purposes, such as quality assurance.

6. **This authorization expires 30 calendar days after the start of the next school year unless marked below. (Only mark if you want a DIFFERENT expiration date)**
   ☐ Expires on this date: _____
   ☐ Permission only applies for the following time period: From (date)_____ to (date)_____
   ☐ Other limitation: Explain.

_____

7. CTC has permission to use my child's photograph for purposes related to informing others about CTC programs and services. I understand my child's name or other personally identifiable information will not be associated with photographs without my express permission.
   ☐ Yes ☐ No

8. I understand that I may revoke this permission. I understand that if this permission is revoked, it may not be possible for my child to continue to participate in certain programs or receive certain services. I may be informed of that possibility if I wish to revoke this permission. I understand records disclosed before this permission is revoked may not be retrieved, and any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work begun because this permission was given.

9. I understand that federal and state law permit health, alcohol or drug abuse records possessed by a school and properly deemed to be educational records to be re-disclosed without the consent of a parent or guardian to schools and other entities authorized to receive educational records, when such re-disclosure is for reasons authorized by law.

10. I understand that Ohio and federal law generally prohibit persons receiving health, alcohol or drug abuse records from re-disclosing those records without permission. I understand that not every organization that may receive health records is required to follow federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORDS AND THE INFORMATION IN THE RECORDS TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 4 FOR THE PURPOSES PERMITTED IN PARAGRAPH 5, BUT FOR NO OTHER PURPOSE.

Parent/Guardian Name (Print)	Parent/Guardian Signature	Date
Student Name (Print)	Student Signature	Date

See Attachment A for list of partners supporting Care Team in my school district.

REFUSAL TO CONSENT

My student, _____, has been offered Care Team Collaborative services and supports. I refuse consent at this time. I understand that my refusal may result in further lack of school success, possibly leading to out of school suspension, court involvement and/or failure to graduate.

Parent/Guardian Name (Print)	Parent/Guardian Signature	Date
Student Name (Print)	Student Signature	Date