# 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 wi	ll be entering				attended Coshocton  If YES: School	
Student Name (LEGAL NAM	TE AS IT APPEARS ON	BIRTH CERT	TFICATE):			Grade(s) Enrolled	
					Last N	Name Suffix (Jr., III, e	etc)
First Gender (circle one)	Middle		Last				
F or M	Social Security #				_	County of I	Residence (circle
one):							
Home Phone: Area Code						Cosh	octon
Street Address						Knox	Holmes
P.O. Box #City	······		Zip	•••••		Licking	Muskingum
STUDENT'S BIRTH DATA							
Date of Birth: Month							:
Birth City							
Citizenship of student:U	SA Other (specify co	untry)	Native Language	e spoken	in home: _	English Other (s	specify language)
If child was born outside the							
.======				•••••			
2. RACIAL /	ETHNIC DATA	i	a ppr//	10110.0	2011001	INCODMATION	
ı	ER BOTH A AND B	I	3. PREVI	1005 5	CHOOL	. INFORMATION	
A. Is the student Hispani (Hispanic/Latino means a person or Central American, or other Spanis	of Cuban, Mexican, Puerto					IEP or 504 plan or rvices in the past?	has he/she re-
Yes No (9	go to part B)	i i		s No		ent copy of IEP and	ETD )
B. Is the student: (check a	all that apply)	i	` '	•			
American Indian or Ala in any of the original pee (including Central Ameri or community attachmen	ples of North and South Ar ica) and who maintain triba	nerica		ent unde	·	on from previous sc	hoo!?
area includes for example	sia, or the Indian subcontine e. Cambodia, China, India.	ent. This				most recently enroll	
Vietnam.)	n, the Philippine Islands, Th	Ī				11	
Black or African Ameri of the black racial groups	i <b>can</b> (Persons having origi s in Africa.)	ns in any	School				
Native Hawaiian or Pac origins in any of the origi or other Pacific Islands.	ific Islander (Persons ha nal peoples of Hawaii, Gua	aving m, Samoa,					
White ( Persons having ori Europe, North Africa, or	the Middle East.)	ì					
(If left blank, ethnicity will be de						1.2	820
Coshocton Opportunity Schoo Department of Education, unde	er the No Child Left Beh	ind Act, to	PLEASE CO	MPLE	TE REVI	ERSE SIDE -	$\rightarrow$ $\langle$

school district.

| 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 Grad	le
4. FAMILY & CUSTODIAL DATA	
• Status of Biological Parents:Parents MarriedParents never	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 t	
(ORC 3313.672) and the Missir	ng Children's Act.
• Student lives with: Mother & Father Mother only Mother	ther & Stepfather Father only Father & Stepmoth
	urt appointed Guardians/Grandparents Other
INFORMATION for Mother /Guardian/ Foster Parent (circle one)	Why do you want to attend Coshocton Opportunity School
N	
	3
Home address Street Address City State Zip	- I
Home Phone: Cell Phone	
Tone Thone.	
Employer Work phone	
INFORMATION for Feeboor (Consults of Feeboor)	
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	No.
	OFFICE STAFF
NFORMATION for Step-Mother /Step-Father (circle one)	HAVE YOU COLLECTED?
ame	— Ludbid Guisuu V V
ome address	Legal Birth Certificate Y N  Proof of Residency Y N
Street Address City State Zip	Immunization Record Y N
ome Phone:Cell Phone	Social Security Card Y N
mployer Work phone	
work phone	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 information provided is true and correct.	the above named student and that the registration
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 authority when parents	orize the provision of emergency to s or guardians cannot be reached.	eatment for chil	dren who become ill
Residential Parent or Guardian			
Mother's Name	Contact Phor	ne #	
Father's Name		ie#	
Other Contact	Contact Phor	ie#	
Name of Relative Living Closest To You			
Relationship	Contact Phon	e #	
AddressStreet			
		State	Zip
PARTIO	R II MUST BE COMPLETED		
Doctor			
Dentist			
ocal Hospital			
In the event reasonable attempts to contact me have of any treatment deemed necessary by above-named available, by another licensed physician or dentist; at this authorization does not cover major surgery unleaded oncurring in the necessity for such surgery, are obtained acts concerning the child's medical history including	been unsuccessful, I hereby give raid doctor, or, in the event the design and (2) the transfer of the child to a less the medical opinions of two other ained prior to the performance of same as the medical opinions.	ny consent for ( ated preferred p my hospital reasoner licensed phy- uch surgery.	l) the administration ractitioner is not onably accessible. sicians or dentists,
ignature of Parent  ART II – REFUSAL TO CONSENT			
do not give my consent for emergency medical treat nergency treatment, I wish the school authorities to	tment of my child. In the event of take the following actions:	illness or injury	requiring
gnature of Parent	Date_		

2021-2022 Coshocton Opportunity School - Household income

Part 1. ALL HOUSEHOLD MEMBERS			FI			mey our		-				J11012 111001				_		
Names of <u>all</u> household members (First, Middle Initial, Last)	Name of school and grade level for child/or indicate "NA" if child is not School			l is not in so	choc			W	elfa f all	ck if a foster child are agency or co children listed t	urt) pelo	w a	re fo		,	Check if No Income		
	GCHOO					Grade	е		S	KIP 1	to Part 5 to sign	tnis	_	m.	_			
		_	_	-	_			_		╁	_		Ī	_				
											_		Ē					
													Ē	]		-		
														]		-		
Part 2. BENEFITS: If any member of your benefits, provide the name and 7-digit case skip to Part 3.  NAME:  Part 3. If any child you are applying for LIAISON, or MIGRANT COORDINATOR]  Homeless	number for	the	per	sor ant	7-D	o receives IGIT CASE a runaway	ber NU	nef JM	fits : IBE	and	sk	ip to Part 5. If	no	one	rec	eive	es these ben	efits,
Part 4. TOTAL HOUSEHOLD GROSS INC	OME (befor	e d	edu	cti	ons	). List all in	con	ne	on	the	saı	me line as the	pers	son	who	o rec	ceives it. Che	eck the
box for how often it is received. Record each	h income on	y o	nce	•			_						_		_			
	2. GROSS I	NC	OM	ΕA	ND	HOW OF	ΓEΝ	П	W	AS	RE	CEIVED		1	_	-		
NAME  (List all household members with income)	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 (indicate fr such as " "monthly" " "annu	requency, 'weekly" 'quarterly"
(Example) Jane Smith	\$200					\$150			X			\$0					\$50.00/ qu	arterly
	\$					\$						\$					\$	7
	\$		П			\$	1	J			П	\$	П	П			\$	/
1	\$	П	-				_	7		$\bar{\Box}$	П	\$	$\overline{\Box}$	H	F	I	\$	7
	\$	$\overline{\Box}$	1	F			- 1-	375			H				믐	믐	\$	1
	\$	H	H	F			-12		님	금	_			H	금	片	\$	<u> </u>
Your permission is required to share your manswering this question will not change who Please check a box:   Yes, I agree to have	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.																	
THE STATE OF THE S	CITE OF SO	CLA	1 6	EC	ш	TV AU IMAD	ED			_		te:			_	_		
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				Prir	t na	me:										Dat	e:	
Address:																		
Last four digits of your Social Security Num	ber:		_		l do	not have	a So	oci	al S	Sec	urity	y Number						
Part 7. Children's ethnic and racial identi important and helps to make sure we are fu eligibility for free or reduced-price meals.	lly serving ou	ır co	omr	nur	ity.	Respondir	ng to	o tł	nis :	sec	yo tion	ur children's rad is optional and	ce a	end es	eth not	nicit affe	y. This inforrect your child	mation is ren's
Choose one ethnicity:	Choose or	ne c	or m										_					
Hispanic/Latino       ☐ Asian       ☐ American Indian or Alaska Native       ☐ Black or African American         Not Hispanic/Latino       ☐ White       ☐ Native Hawaiian or other Pacific Islander						an												

## ANNUAL MEDICAL UPDATE 2021-2022

STUDENT NAME	DATE OF BIRTH	В	UILDING	GRADE & TEACHER
I. HEALTH CONDITIONS — Please, check	cany that this student has had:	DATE OF LAST EXA	M: PHYSICAL	DENTAL
Abnormal spinal curvatur	e (scoliosis, etc.)	Diabetes		Rheumatic Fever
Allergies or hay fever (list		_Diarrhea, or Constipation	-	Rubella (3 day measles)
Anemia		Eczema	_	Seizures/epilepsy
Arthritis		Emotional Problems		Sickle Cell disease
Asthma		_Headaches (frequent)		Skin rashes (frequent)
Behavior problems		Heart Disease		Stool soiling
Birth or congenital malfo	ormation	_Hepatitis	_	Throat infections (frequent)
Cancer, Type		_Kidney Disease	_	Tics/nervous twitches
Chicken Pox		_Measles (10 day)	9-	Tuberculosis or + TB
Concern about siblings/frie		_Meningitis or Encephalitis	-	Urinary Tract Infections
Cystic Fibrosis		_Mumps	_	Wetting (daytime/night)
II. YISION AND HEARING	20 216			7.00
	Which ear?			
	When?			In place?
Wears glasses/contacts (circle	)? Reason? (circle) Distance Cl	lose-up Other-explain		
III. INJURIES/ILLNESSES/SURGERIES— Plea		s or illnesses:		
	Injuries/Illnesses/Surgery		Age	Hospitalized/Treatment
			1	
				7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7
			- 1	
L				
Commonts (mars cooks provided on back	of annals			
Comments (more space provided on back	or page)			
1000				
IV. ADDITIONAL INFORMATION				
DAILY medication, dosage, condition	being treated:	MEDICATIO	ON or ENVIRONMENT	AL ALLERGIES:
140				
Medications taken frequently but no	t daily & reason:			
	4			
				1.039
Cinning halam gives	ha echani numa en enteres unum -l	sild'e abveisiae sansanina san	hanlth earn ennea	and for this information to be should with sales and
		inu s physician concerning any	nearur care concerns	and for this information to be shared with school stal
needed to care for your child during the	ZUIS/ZUID SCHOOL YEAR.			
AAUDI ETER BUS		DELATIONELLI TO CHILDREN		DATE
COMPLETED BY:		KELATIONSHIP TO STUDENT:		DATE:

Please attach any other relevant medical information, if necessary. Addition comments concerning health issues, medications & concerns:
A STATE OF THE STA

### 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  I have read and understand the Student Handbook.
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.
Parent Initials Student Initials MEDIA PUBLISHING 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:
<ul> <li>The district will not publish a student's last name, address, phone, age or written description on our website.</li> <li>Individual pictures will only be posted with first name and only if consent is granted above.</li> <li>Groups of students in photos will have no names attached.</li> </ul>
Parent Initials  RIGHT TO SEARCH ARGEEMENT  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.
Parent Initials Student Initials  I will be financially responsible for any lost or damaged school property.
USE OF TRAINED DOGS  Student Initials  Student Initials

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

## ZERO TOLERANCE PERTAINING TO DRUGS AND

Parent Initials Student Initials 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.

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

Parent Initials Student Initials

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 QUALIFICATIONS 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   Student Initials   POLICY NO. 3680				
Parent Initials  Student Initials  Parent Initials  TRACKING MISSING CHILDREN  Policy No. 3833  STUDENT FINGERPRINTING	Student's Si	gnature	Student's Printed Name	Da
Parent Initials  Student Initials  TRACKING MISSING CHILDREN Policy No. 3833  Policy No. 3833	Parent Initials	Student Initials	POLICY NO. 6140	
Parent Initials  Student Initials  TRACKING MISSING CHILDREN			STUDENT FINGERPRINTING	
Parent Initials  Student Initials  Student Initials  Student Initials  Parent Initials  Student Initials  Student Initials  Student Initials  Policy No. 3710.2	Parent Initials	Student Initials		
Parent Initials Student Initials INDEPENDENT EDUCATIONAL EVALUATION POLICY NO. 3710.2  STUDENT RECORDS AND RELEASE OF INFORMATION			FORM NO. 3831.1	
INDEPENDENT EDUCATIONAL EVALUATION	Parent Initials	Student Initials		ORMATIO
Parent Initials Student Initials POLICY NO. 3680	Parent Initials	Student Initials		ON
	Parent Initials	Student Initials	POLICY NO. 3680	



#### (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.

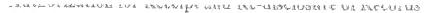
You may request a copy of any records that are disclosed pursuant to this authorization. The CTC will maintain a record of each disclosure of personally identifiable information from your child's records. This record will be maintained with your child's education records as long as these records are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



Page 1 of 4

OCare Team Collaborative 8/2008 (Timmons). This protocol is designed exclusively for Care Team Collaborative partners. It is to be used only in conjunction with the Care Team Collaborative Release of Information Packet (8/2008). Others, contact CTC at 205 N. 7th Street, Zanesville, OH 43701 for permission.





#### 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
Coshocton County Health Department
Coshocton County Board of MR/DD
Mental Health & Recovery Services
Department of Youth Services
Thompkins Child & Adolescent Services
Coshocton Behavioral Health Services
Family PACT
Coshocton County WIC
Muskingum Valley Educational Service Center
Art Therapy

Ed & Chris Gallagher

Six County, Inc.
Coshocton City Health Department
Coshocton City Schools
Big Brothers/ Big Sisters
Coshocton County Juvenile Court
Coshocton County Family & Children First
Council
Help Me Grow
First Step Family Intervention Services
Coshocton County GRADS
Care Team Collaborative
JOG
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:
Na	me: Date of Birth:Soc. Sec. #
	The information that may be used or disclosed includes (initial all that apply):  Education Records Health Records, including Protected Health Information  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 persons or organizations who provide services to my child (list below):
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):
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.
1	This authorization expires 30 calendar days after the start of the next school year unless narked 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.
	Page 2 of

Page 3 of 4

<sup>&</sup>lt;sup>©</sup>Care Team Collaborative 8/2008 (Timmons). This protocol is designed exclusively for Care Team Collaborative partners. It is to be used only in conjunction with the Care Team Collaborative Release of Information Packet (8/2008). Others, contact CTC at 205 N. 7<sup>th</sup> Street, Zanesville, OH 43701 for permission.

DE LA
Care Team Collaborative
7. CTC has pe
CTC progr

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.     No									
8.	services. I may be informed of the records disclosed before this per organization that relied on this p	is permission. I understand that if the to continue to participate in certain nat possibility if I wish to revoke this mission is revoked may not be retribermission may continue to use or discomplete work begun because this properties.	n programs or receive certain s permission. I understand eved, and any person or isclose records and protected							
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	drug abuse records from re-disclevery organization that may recegoverning use and disclosure of TO THE PERSONS AND ORGATHIS AUTHORIZATION TO REIN THE RECORDS TO PERSOFOR THE PURPOSES PERMIT	al law generally prohibit persons recosing those records without permissive health records is required to foll protected health information. I HE ANIZATIONS THAT RECEIVE RE-DISCLOSE THE RECORDS AND OR ORGANIZATIONS DESCRIPTION OR ORGANIZATIONS DESCRIPTION PARAGRAPH 5, BUT FOR THE PROTECTION OF THE P	sion. I understand that not low federal HIPAA rules REBY GIVE PERMISSION ECORDS PURSUANT TO ND THE INFORMATION RIBED IN PARAGRAPH 4 OR 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.									
3	Parent/Guardian Name (Print)	Parent/Guardian Signature	Date							
3	Student Name (Print)	Student Signature	Date							
			Page 4 of 4							

<sup>o</sup>Care Team Collaborative 8/2008 (Timmons). This protocol is designed exclusively for Care Team Collaborative partners. It is to be used only in conjunction with the Care Team Collaborative Release of Information Packet (8/2008). Others, contact CTC at 205 N. 7<sup>th</sup> Street, Zanesville, OH 43701 for permission.

### COSHOCTON OPPORTUNITY SCHOOL

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#### PLEASE PRINT - PARENT/GUARDIAN SHOULD COMPLETE ALL INFORMATION.

1. STUDENT DATA	Grade student will	be entering		attended Coshocton If YES: School	
Student Name (LEGAL NAM	1E AS IT APPEARS ON E	BIRTH CERTIFICATE)		Grade(s) Enrolled	
First	Middle	Last	Last Na	ame Suffix (Jr., III,	etc)
Gender (circle one)					
F or M one):	Social Security #			County of 1	Residence (circle
Home Phone: Area Code		Unlisted	? Yes No	Cosh	octon
Street Address				Knox	Holmes
P.O. Box # City	,	Zip		Licking	Muskingum
STUDENT'S BIRTH DATA			•••••		
Date of Birth: Month					:
Birth City					:
Citizenship of student:US	SA Other(specify countr	Native Lang	uage spoken in home:	English Other(s	pecify language)
If child was born outside the	U.S., how many years h		ıg a U.S. school?		
		7			
2. RACIAL /	ETHNIC DATA	1			
PLEASE ANSWE	R BOTH A AND B	3. PRE	EVIOUS SCHOOL	INFORMATION	
A. Is the student Hispanie (Hispanie/Latino means a person or Central American, or other Spanish	of Cuban, Mexican, Puerto Ric		your child have an I special education serv		has he/she re-
Yes No (g	o to part B) —		YesNo	·	
B. Is the student: (check a	II that apply)	1 (1	f yes, provide a curren	nt copy of IEP and E	ETR.)
in any of the original peop	ska Native (Persons having oles of North and South Ameri a) and who maintain tribal aff	ca	ident under expulsion Yes No	n from previous sch	1001?
Asian (Persons having orig the Far East, Southeast As area includes, for example	ins in any of the original peop ia, or the Indian subcontinent, Cambodia, China, India, Japa	This Scho	ol where child was m	ost recently enrolle	ed:
Vietnam.)	the Philippine Islands, Thaila	District_			
of the black racial groups	,	J School_			
Native Hawaiian or Paci origins in any of the origin or other Pacific Islands.	fic Islander (Persons havin al peoples of Hawaii, Guam, S	Samoa,	Address		
White ( Persons having orig Europe, North Africa, or th	ins in any of the original peop ne Middle East.)	ies or			
(If left blank, ethnicity will be det	ermined by observer identif	ication)			
Coshocton Opportunity School Department of Education, under collect and report this informatio	the No Child Left Behind	Act, to FLEASE	COMPLETE REVER	RSE SIDE	$\rightarrow$ $\langle$

school district.

I 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 M	Married Parcnts 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  (ORC 3313.672) and the Missing	
◆ Student lives with:Mother & FatherMother onlyMother	
INFORMATION for Mother /Guardian/ Foster Parent (circle one)  Name	Why do you want to attend Coshocton Opportunity School?
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	
NFORMATION for Step-Mother/Step-Father (circle one)	OFFICE STAFF HAVE YOU COLLECTED?
First M.L. Last  Tome address  Street Address City State Zip	Legal Birth Certificate Y N Proof of Residency Y N
Iome Phone:Cell Phone	Immunization Record Y N Social Security Card Y N
Employer Work phone	Legal Custody Documents Y N  Court/Foster Placement Form Y N  Copy of IEP, if applicable Y N
5. PARENT / GUARDIAN SIGNATURE	copy of int, it applicable 1 14
I, the undersigned, state that I am the parent or legal guardian of the information provided is true and correct.  Signature of	ne above named student and that the registration

Parent/Legal Guardian X

Date: **X** \_\_\_\_\_

# COSHOCTON OPPORTUNITY SCHOOL EMERGENCY MEDICAL AUTHORIZATION

Student Name:	Telephone	#:	
Student Address:Street			
Street	City	State	Zip
Purpose: To enable parents and guardians to authoriz injured while under school authority, when parents or	te the provision of emergency guardians cannot be reached.	treatment for chil	dren who become ill
Residential Parent or Guardian			
Mother's Name	Contact Pho	one #	
Father's Name		me #	
Other Contact		ne#	
Name of Relative Living Closest To You			
Relationship		ne #	
Address			
Address Street	City	State	Zip
PARTIORI	I MUST BE COMPLETED		•
Doctor  Dentist  Addical Specialist	Phone		
PART I - TO GRANT CONSENT I hereby give consent for the following medical care pr	oviders and local hospitals to	be called:	
Dentist Medical Specialist	Phone		
Medical Specialist			
Local Hospital	Emergency R	oom Phone	T
In the event reasonable attempts to contact me have been of any treatment deemed necessary by above-named downailable, by another licensed physician or dentist; and other major surgery unless to concurring in the necessity for such surgery, are obtained acts concerning the child's medical history including a thich a physician should be alerted:	ctor, or, in the event the design (2) the transfer of the child to the medical opinions of two of the performance of	nated preferred prainty hospital reason, the licensed physical surgery.	cactitioner is not onably accessible. sicians or dentists,
ignature of Parent	Date		
ART II - REFUSAL TO CONSENT	17/541-1107		
do not give my consent for emergency medical treatme nergency treatment, I wish the school authorities to tak	nt of my child. In the event of the following actions:	fillness or injury	requiring
gnature of Parent	Date		

2021-2022 Coshocton Opportunity School - Household income

Part 1. ALL HOUSEHOLD MEMBERS	- COMOCIOI		44			nty O	0110	<u>.                                    </u>	Ť		450	moid mooi	110					
Names of <u>all</u> household members (First, Middle Initial, Last)	Name of school child/or indicate						n scho			W	elfa If all	k if a foster child re agency or co children listed t	urt) pelov	w ar	e fo			Check if No Income
	School Grade					S	skip to Part 5 to sign this form.											
									-5-									
										T		·						
	10000 00 0000 0000																	
Part 2. BENEFITS: If any member of your benefits, provide the name and 7-digit case skip to Part 3.  NAME:  Part 3. If any child you are applying for	e number for	the	per	son	wh 7-D	o recei <sup>.</sup> IGIT C <i>i</i>	ves b ASE N	ene IUN	fits 1BE	and	d sk	ip to Part 5. If	no (	one	rec	eive	es these ben	efits,
LIAISON, or MIGRANT COORDINATOR] Homeless  Migrant  Runaway	at [EMAIL] o	or [F	PHC	NE	NU	JMBER	₹].											
Part 4. TOTAL HOUSEHOLD GROSS INC box for how often it is received. Record each	ch income on	e de ly oi	e <b>au</b> nce	ctic	ns	j. List a	III Inco	me	on	tne	saı	ne line as the	pers	on v	who	rec	ceives it. Ch	eck the
	2. GROSS I	_			ND	HOW	OFTE	Νľ	ΓW	AS	RE	CEIVED						
NAME (List all household members with income)	Earnings from work before deductions	Weekly	eks	Т			fare, ild port,	Weekly	sks	T		Pensions,	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All Other (indicate fi such as ' "monthly" ' "annu	requency, 'weekly" 'quarterly"
(Example) Jane Smith	\$200	×		$\vdash$		\$15	50		Ø			\$0			П		\$50.00/ qu	arterly
, and a second control of the second control	\$		1.5	F	F	\$			Ultimate	Dealer		99411		$\overline{\Box}$	$\bar{\Box}$		S. A. S.	7
	\$	Ħ	ī			1 \$		П					ī	Ē	$\overline{\Box}$	n	\$	7
	\$			F		1 \$			-		100			H	$\bar{\Box}$	П	\$	7
	\$			F	F	\$				t		\$	F	$\overline{\Box}$			\$	,
	\$		_	=		1 \$		F	F		100	\$	H	H	$\overline{\Box}$	n	\$	7
Part 5. SCHOOL INSTRUCTIONAL FEE of Your permission is required to share your in Answering this question will not change who Please check a box: Yes, I agree to have No, I do not agree Signature of Parent/Guardian:	neal applicati ether your ch e my meal ap	ion i nildr plic	nfo en v atio	rma will on u	tior rece sed	with seive fre	chool e or r ermin	offi edu e if	cial ced my	s to I-pri chil	dei ice i ld(re	termine if your meals. en) qualifies for	chile a fe	d(re ee w	n) c ⁄aiv	ual er	ifies for a fe	al fees. e waiver.
Part 6. SIGNATURE AND LAST FOUR DI	GITS OF SO	CIA	LS	EC	UR	ITY NU	MBE	R (	ADI	JLT	MU	JST SIGN)						
An adult household member must sign the his or her Social Security Number or ma I certify (promise) that all information on thi funds based on the information I give. I und misrepresentation of the information may costatutes.	rk the "I do s application derstand that	not is ti sch	ha rue ool	<b>ve a</b> and offi	Solution Solution	ocial So at all ind s may v	ecuri come verify	i <b>y N</b> is r (ch	lum epo eck	rted ) th	r" <b>b</b> d. I d e in:	ox. (See Privacy understand tha formation. I un	Act : t the ders	State sca tand	mer hoo d th	it on I wi at o	the back of thi Il receive fed leliberate	s page.) deral
Sign here: X				Prir	it na	ame:										Da	te:	
Address:												_Phone Numl	oer:					
Last four digits of your Social Security Num															-41-		to. This isfa	tion in
Part 7. Children's ethnic and racial ident important and helps to make sure we are fu eligibility for free or reduced-price meals.	ully serving o	ur c	omi	mur	ity.	Respo	nding	to	this	se								
Choose one ethnicity:	Choose o		or n			57.0					.1	NI-45		D1-	-1-	A	[ A '	
☐ 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	BU	ILDING	GRADE & TEACHER
I. HEALTH CONDITIONS $-$ Please, check	any that this student has had:	DATE OF LAST EXAM	: PHYSICAL	DENTAL
Abnormal spinal curvature	(scalinsis etc.)	Diabetes		Rheumatic Fever
Allergies or hay fever (list t		Diarrhea, or Constipation	-	Rubella (3 day measles)
Anemia		Eczema	•	Seizures/epilepsy
Arthritis		Emotional Problems	-	Sickle Cell disease
Asthma	-	Headaches (frequent)	2.	Skin rashes (frequent)
Behavior problems	-	Heart Disease	-	Stool soiling
Birth or congenital malfor	mation —	Hepatitis	-	Throat infections (frequent)
Cancer, Type			•	
Chicken Pox		Measles (10 day)		Tuberculosis or + TB
Concern about siblings/frien	d relationship	Meningitis or Encephalitis	12	Urinary Tract Infections
Cystic Fibrosis		Mumps	-	Wetting (daytime/night)
Please comment, as you feel necessary, on	any of the above (more space			
II. VISION AND HEARING	<b>9</b> .11	View Control		
Frequent ear infections?	Which ear?	How often?		
		P.E. Tubes?		In place?
Wears glasses/contacts (circle)?	Reason? (circle) Distance	Close-up Other-explain		
INTERPRETATION OF THE PROPERTY	. List may engageine Saling			
II. INJURIES/ILLNESSES/SURGERIES— Please	Injuries/Illnesses/Surgery	ies or illilesses.	1	Unanitational Management
	mjuries/mnesses/surgery		Age	Hospitalized/Treatment
	W—			101
	■ Controller			
omments (more space provided on back o	of page):			
. ADDITIONAL INFORMATION				
	ning translate	MEDICATION	I CHUBOUMEU	TAL ALLEDCIES.
DAILY medication, dosage, condition b	eing treated:	MEDICATION	or ENVIRONMEN	IAL ALLENGIES:
Medications taken frequently but not	daily & reason:			2-X00-01-01-0-0
11-93-93-1-81				
				1.70
		child's physician concerning any he	ealth care concern	s and for this information to be shared with school s
eeded to care for your child during the 2	1015/2016 school year.			
OMDISTED BY		ACLATIONISHID TO CONDENT		DATE
COMPLETED BY:		RELATIONSHIP TO STUDENT:		DATE:

Please attach any other relevant medical information, if necessary. Addition comments concerning health issues, medications & concerns:
Extra elikining a CC — 1 a CC

### 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.

Parent Initials Student Initials  I have read and understand the Student Handbook.
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.
Parent Initials Student Initials MEDIA PUBLISHING 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:
<ul> <li>The district will not publish a student's last name, address, phone, age or written description on our website.</li> <li>Individual pictures will only be posted with first name and only if consent is granted above.</li> <li>Groups of students in photos will have no names attached.</li> </ul>
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.
Parent Initials Student Initials I will be financially responsible for any lost or damaged school property.
Parent Initials Student Initials USE OF TRAINED DOGS

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

drug or any d school vehicl	rug-related para es, and at any s	ZERO TOLERANCE PERTAINING TO DRUGS AND ALCOHOL pol prohibits the use, possession, concealment or distribution of any aphernalia as the term as defined by law, on school grounds, on chool-sponsored events. The minimum punishment for violation of discipline section of the handbook.
my student. I and place of b	Directory inform pirth, major field	FERPA and DIRECTORY INFORMATION (Policy #*****) on Opportunity School to release directory information regarding nation may include: student's name, address, telephone number, date d of study, participation in activities and sports, height and weight if its, dates of attendance, date of graduation or awards received.
Parent Initials	Student Initials	GOVERNING AUTHORITY MEMBERS QUALIFICATIONS 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
		CRISIS MANAGEMENT AND RESPONSE PLAN

Parent Initials Student Initials POLICY NO. 2630

Parent Initials Student Initials POLICY NO. 3670

Parent Initials

Parent Initials

ADMISSION PROCEDURE POLICY NO. 3511

\_\_\_\_\_ COLLEGE CREDIT PLUS

Student Initials POLICY NO. 3512

KINDERGARTEN AND FIRST GRADE ADMISSION

Parent/Guar	dian's Signatu	re Parent/Guardian's Printed Name	Date
Student's Si	gnature	Student's Printed Name	Date
Parent Initials	Student Initials	STUDENT FINGERPRINTING POLICY NO. 6140	
Parent Initials	Student Initials	TRACKING MISSING CHILDREN POLICY NO. 3833	
Parent Initials	Student Initials	STUDENT RECORDS AND RELEASE OF INI POLICY NO. 3831 FORM NO. 3831.1	FORMATION
Parent Initials	Student Initials	INDEPENDENT EDUCATIONAL EVALUATI POLICY NO. 3710.2	ON
Parent Initials	Student Initials	CAREER ADVISING POLICY NO. 3680	



# (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.



Page 1 of 4

<sup>&</sup>lt;sup>6</sup>Care Team Collaborative 8/2008 (Timmons). This protocol is designed exclusively for Care Team Collaborative partners. It is to be used only in conjunction with the Care Team Collaborative Release of Information Packet (8/2008). Others, contact CTC at 205 N. 7<sup>th</sup> Street, Zancsville, OH 43701 for permission.





#### 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	Six County, Inc.
Services	Coshocton City Health Department
Coshocton County Health Department	Coshocton City Schools
Coshocton County Board of MR/DD	Big Brothers/Big Sisters
Mental Health & Recovery Services	Coshocton County Juvenile Court
Department of Youth Services	Coshocton County Family & Children First
Thompkins Child & Adolescent Services	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:
Na	me: Date of Birth: Soc. Sec. #
	The information that may be used or disclosed includes (initial all that apply): Education RecordsAlcohol or Drug Treatment RecordsHealth Records, including Protected HealthAll of the records listed Information
3.	This information may be disclosed by (initial all that apply): Any person or organization possessing theThe persons or organizations information to be disclosed listed in Attachment AThe following persons or organizations who provide services to my child (list below):
4.	This information may be disclosed to (initial all that apply): Any person, organization that needs theThe persons or organizations information to provide services to my child, pay for those services, engage in quality assurance or other health care operations related to that personThe following persons or organizations (list below):
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 narked 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.
	Daga 2 of

Page 3 of 4

<sup>&</sup>lt;sup>9</sup>Care Team Collaborative 8/2008 (Timmons). This protocol is designed exclusively for Care Team Collaborative partners. It is to be used only in conjunction with the Care Team Collaborative Release of Information Packet (8/2008). Others, contact CTC at 205 N. 7<sup>th</sup> Street, Zanesville, OH 43701 for permission.

-	D.	<i>!</i>	Ĩ	通	-
Care	Tean	1 (	oll	abora	ti

Student Name (Print)

2.55					
am Collaborative					
unormation will not be associat	hild's photograph for purposes rela understand my child's name or oth ted with photographs without my e No	er nargamally identifically			
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.					
<ol> <li>I understand that federal and sta a school and properly deemed to a parent or guardian to schools such re-disclosure is for reasons</li> </ol>	o be educational records to be re-di and other entities authorized to rec	sclosed without the consent of			
governing use and disclosure of TO THE PERSONS AND ORGINE THIS AUTHORIZATION TO IN THE RECORDS TO PERSONS	ral law generally prohibit persons relosing those records without permieive health records is required to for protected health information. I HEANIZATIONS THAT RECEIVE RE-DISCLOSE THE RECORDS ADDS OR ORGANIZATIONS DESTITED IN PARAGRAPH 5, BUT I	ssion. I understand that not ollow federal HIPAA rules EREBY GIVE PERMISSION RECORDS PURSUANT TO AND THE INFORMATION CRIBED IN PARAGRAPH 4			
Parent/Guardian Name (Print)	Parent/Guardian Signature	Date			
Student Name (Print)	Student Signature	Date			
My student,supports. I refuse consent at this ti	partners supporting Care Tea  REFUSAL TO CONSENT  , has been offered Care ime. I understand that my refusal may school suspension, court involvement	Team Collaborative services and result in further lack of school			
Parent/Guardian Name (Print)	Parent/Guardian Signature	Date			

Page 4 of 4

Date

<sup>o</sup>Care Team Collaborative 8/2008 (Timmons). This protocol is designed exclusively for Care Team Collaborative partners. It is to be used only in conjunction with the Care Team Collaborative Release of Information Packet (3/2008). Others, contact CTC at 205 N. 7<sup>th</sup> Street, Zanesville, OH 43701 for permission.

Student Signature