

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. 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

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 REGISTRATION FORM 24-25 School year

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 City Schools? 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**
 one):

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 _____ Native Language spoken in home: ___ English Other _____
(specify country) (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 City Schools 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 →

COSHOCOTON 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 _____

**ANNUAL MEDICAL UPDATE
2024-2025**

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 _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal spinal curvature (scoliosis, etc.) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies or hay fever (list below in section IV) | <input type="checkbox"/> Diarrhea, or Constipation | <input type="checkbox"/> Rubella (3 day measles) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Sickle Cell disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches (frequent) | <input type="checkbox"/> Skin rashes (frequent) |
| <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Birth or congenital malformation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Throat infections (frequent) |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tics/nervous twitches |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles (10 day) | <input type="checkbox"/> Tuberculosis or + TB |
| <input type="checkbox"/> Concern about siblings/friend relationship | <input type="checkbox"/> Meningitis or Encephalitis | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mumps | <input type="checkbox"/> 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: _____

Household Income School Year 2024-2025

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

Child's First Name	MI	Child's Last Name	Grade	Foster/Child	Migrant	Runaway	Homeless
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check all that apply

If you checked any of these boxes, please refer to the Application's Instruction's Step 1: Part C & Part D.

STEP 2 Do any household members (including you) participate in: SNAP, TANF, or FDIPIR?

NO → Go to STEP 3. YES → Write case number here and proceed to STEP 4.

Write only one case number in this space.

STEP 3 List ALL household members and income for each member (before taxes and deductions)

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.)
List all Adult Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work			Public Assistance, Child Support, Alimony			Pensions, Retirement, Social Security, VA Benefits, All Other		
	Weekly	2-Month	Monthly	Weekly	2-Month	Monthly	Weekly	2-Month	Monthly
	\$			\$			\$		
	\$			\$			\$		
	\$			\$			\$		
	\$			\$			\$		
	\$			\$			\$		

Total Household Members (Children and Adults) Check if no Social Security Number

B. Child Income
Sometimes children in the household earn or receive income. Include the TOTAL Income (before taxes and deductions) received by ALL children listed in STEP 1 here. \$

Child Income: Weekly Every 2 Weeks 2-Month Monthly Annual

Please see application's back for list of income sources.

STEP 4 Contact information and adult signature. RETURN COMPLETED FORM TO YOUR CHILD'S SCHOOL: Insert school address here

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (confirm) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.*

Print Name of Adult Signing the Form Signature of Adult Today's Date

Mailing Address (if available) City State Zip Phone (optional) Email (optional)

Return completed form to your child's school.

SOURCES AND EXAMPLES OF INCOME

For additional information on income, please refer to the instructions that accompany this application.

Sources of Income		Examples of Income for Children
<p>Earnings from Work</p> <ul style="list-style-type: none"> Salary, wages, cash bonuses, tips, commissions Net income from self-employment (farm or business) <p>If you are in the U.S. Military:</p> <ul style="list-style-type: none"> Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) Allowances for off-base housing, food, and clothing 	<p>Public Assistance/Alimony/Child Support</p> <ul style="list-style-type: none"> Unemployment benefits Workers' compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits 	<ul style="list-style-type: none"> A child has a regular full or part-time job where they earn a salary or wages A child is blind or disabled and receives Social Security benefits A parent is disabled, retired, or deceased, and their child receives Social Security benefits A friend or extended family member regularly gives a child spending money A child receives regular income from a private pension fund, annuity, or trust
<p>Pensions/Retirement/All other sources of income</p> <ul style="list-style-type: none"> Social Security/Disability (including railroad retirement and black lung benefits) Private Pensions or disability benefits Income from trusts or estates Annuities Investment income Earned interest Rental income Regular cash payments from outside household 		

OPTIONAL

Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

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.

Ethnicity (check one): Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) Not Hispanic or Latino

Race (check one or more): American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

Return this completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights.

DO NOT FILL OUT For school use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income

How often? Weekly Every 2 Weeks 2x Month Monthly Annual

Household size

Categorical Eligibility

Eligibility Free Reduced Denied

Determining Official's Signature Date

Confirming Official's Signature Date

Verifying Official's Signature Date

Use of Information Statement

The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met. Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, Check if no Social Security Number. Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number. Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

The contact information below is solely to file a complaint of discrimination

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

*MAIL: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (833) 256-1665 or (202) 690-7442; or
program.intake@usda.gov

EMAIL: program.intake@usda.gov

*Do not mail applications to this address, only complaints of discrimination.

Return completed form to your child's school.

This institution is an equal opportunity provider.

STUDENT – PARENT/GUARDIAN SIGNATURE FORM 2024-2025

**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 AGREEMENT

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**



(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

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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.)
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©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. 7th Street, Zanesville, OH 43701 for permission.

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 _____ Alcohol or Drug Treatment 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 listed in Attachment A
_____ The 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 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 persons or organizations listed in Attachment A
_____ 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.

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

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