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**

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 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 →

Rev. 04/2010

COSHOCTON OPPORTUNITY SCHOOL REGISTRATION FORM

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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_____

Email address:_____

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_____

Email address: _____

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

Name _____
First M.I. Last

Home address _____
Street Address City State Zip

Home Phone:_____ Cell Phone _____

BROTHERS AND SISTERS

Name	Age	Grade

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 _____

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** _____

_____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:_____

4/18/15

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

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
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

Check all that apply

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

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

○ **NO** → Go to STEP 3. ○ **YES** → Write case number here and proceed to STEP 4. **CASE NUMBER (NOT EBT NUMBER):**

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	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Annual	Public Assistance, Child Support, Alimony	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Pensions, Retirement, Social Security, SSI, VA Benefits, All Other	How often received? Weekly	Every 2 Weeks	2x Month	Monthly
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Numbers of Social Security Number of Primary Wage Earner or other Adult Household Member (If Applicable)

Check if no Social Security Number ☐

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

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	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Annual
$	○	○	○	○	○

STEP 4 **Contact information and adult signature.** **<u>RETURN COMPLETED FORM TO YOUR CHILD'S SCHOOL:</u>** 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
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**	
• Salary, wages, cash bonuses, tips, commissions • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers' compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• 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	• 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

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 × 52, Every 2 Weeks × 26, Twice a Month × 24, Monthly × 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
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 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