MOHAWK LOCAL SCHOOL DISTRICT

STUDENT REGISTRATION FORM

All personal information will be kept in the strictest confidence in accordance with the school district's policies on confidentiality of personally identifiable student information.

Today's Date: _____ Enrollment Date: _____ Grade: _____

First Name _____ Middle Name _____ Last Name _____

Date of Birth: _____ Age: _____ Gender: Male or Female

Home Phone: ( )_____ Unlisted: Yes or No

Cell Phone: ( )_____

Street Address: _____

City/State/Zip: _____

Place of Birth (City, State & Country): _____

ETHNICITY: (Check one)

_____ W-White, Non-Hispanic
_____ B-Black, Non-Hispanic
_____ H-Hispanic
_____ A-Asian or Pacific Islander
_____ I-American Indian or Alaskan Native
_____ M-Multi-Racial

CITIZENSHIP STATUS: (Check one)

_____ U.S. Citizen
_____ Exchange Student
_____ Other/Non-U.S. Citizen

If student is a Non-U.S. Citizen
Country of Origin: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1
Name: _____
Place of Employment: _____
Work Phone: _____
Home Phone: _____
Relationship to Student: _____
Does Student Live with the Parent? Yes or No
Home address if different than student's:

_____

_____
Email Address: _____

Parent/Guardian #2
Name: _____
Place of Employment: _____
Work Phone: _____
Home Phone: _____
Relationship to Student: _____
Does Student Live with the Parent? Yes or No
Home address if different than student's:

_____

_____
Email Address: _____

STATEMENT OF CUSTODY (Biological parent information)

Parents married to each other? Yes or No
Parents divorced from each other? Yes or No
If divorced, from what County _____ State _____
Parents separated from each other? Yes or No
Have the biological parents ever been married to each other? Yes or No
Parents Deceased? Yes or No Father Mother
Who has Legal custody of this student? _____

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

SIBLINGS

Name	Grade/Age

OTHERS LIVING IN THE HOME

Name	Relationship

EMERGENCY CONTACTS OTHER THAN PARENT/GUARDIAN

Parent/Guardian will be contacted before the names listed below (unless noted). Please list at least two additional names of contacts.

First Contact: _____ Second Contact: _____

Relationship to Student: _____ Relationship to Student: _____

Daytime or Cell Phone: _____ Daytime or Cell Phone: _____

PREVIOUS SCHOOL INFORMATION

Last School Attended: _____ Last Grade Enrolled or Completed: _____

Address: _____

Previous School Phone: _____

Has this student ever attended Mohawk School District? Yes or No

Previous Kindergarten Experience (half day, full day, full day every other day): _____

Is your child currently expelled from another Ohio District? Yes or No

Is the child presently under suspension or dismissal for academic or disciplinary reasons from any school? Yes or No

If yes, please explain: _____

SPECIAL SERVICES (if applicable)

Please check if your child is currently receiving any of the following services:

_____ Individualized Education Program (IEP)
_____ Special Education Tutoring
_____ Special Education Classroom
_____ Gifted Education
_____ Multi-Factored Evaluation (MFE)
_____ Reading Tutoring
_____ Occupational Therapy
_____ Speech

TRANSPORTATION (For bus driver use):

Where do you live? Describe how to get to your home. _____

PARENT/GUARDIAN CERTIFICATION

I state that the information provided is true and correct. I am aware that the Mohawk Local School District may use any legal means to verify my residence. I understand that falsification of information may be cause for withdrawal of my child from the Mohawk Local School District and subject me to the applicable civil and criminal penalties.

_____
Parent/Guardian Signature Date

_____
Enrollment Secretary Signature Date

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History *Please list allergies, heart problems, diabetes, cancer or other serious health conditions.*

Father

Mother

Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /

MOHAWK LOCAL SCHOOLS

STUDENT NETWORK AND INTERNET ACCEPTABLE USE AND SAFETY AGREEMENT

To access e-mail and/or the Internet at school, students under the age of eighteen (18) must obtain parent permission and must sign and return this form. Students eighteen (18) and over may sign their own forms.

Use of the Internet is a privilege, not a right. The Board's Internet connection is provided for educational purposes only. Unauthorized and inappropriate use will result in a cancellation of this privilege.

The Board has implemented technology protection measures which block/filter Internet access to visual displays that are obscene, child pornography or harmful to minors. The Board also monitors online activity of students in an effort to restrict access to child pornography and other material that is obscene, objectionable, inappropriate and/or harmful to minors. Nevertheless, parents/guardians are advised that determined users may be able to gain access to information, communication and/or services on the Internet which the Board of Education has not authorized for educational purposes and/or which they and/or their parents/guardians may find inappropriate, offensive, objectionable or controversial. Parents/Guardians assume this risk by consenting to allow their students to participate in the use of the Internet. Student's accessing the Internet through the school's computers assume personal responsibility and liability, both civil and criminal, for unauthorized or inappropriate use of the Internet.

The Board has the right to monitor, review and inspect any directories, files and/or messages residing on or sent using the Board's computers/networks. Messages relating to or in support of illegal activities will be reported to the appropriate authorities.

Please complete the following information:

Student User's Full Name (please print): _____

School: _____ Grade: _____

Parent/Guardian's Name: _____

Parent/Guardian

As the parent/guardian of this student, I have read the Student Network and Internet Acceptable Use and Safety Policy and Guidelines, and have discussed them with my child. I understand that student access to the Internet is designed for educational purposes and that the Board has taken available precautions to restrict and/or control student access to material on the Internet that is obscene, objectionable, inappropriate and/or harmful to minor. However, I recognize that it is impossible for the Board to restrict access to all objectionable and/or controversial materials that may be found on the Internet. I will not hold the Board (or any of its employees, administrators or officers) responsible for materials my child may acquire or come in contact with while on the Internet. Additionally, I accept responsibility for communicating to my child guidance concerning his/her acceptable use of the Internet - i.e., setting and conveying standards for my daughter/son to follow when selecting, sharing and exploring information and resources on the Internet. I further understand that individuals and families may be liable for violations.

To the extent that proprietary rights in the design of a web site hosted on the Board's servers would vest in my child upon creation, I agree to assign those rights to the Board.

Please check each that applies:

- ☐ I give permission for my child to use and access the Internet at school and for the Board to issue an Internet/e-mail account to my child.
- ☐ I give permission for my child's image (photograph) to be published online, provided only his/her first name is used.
- ☐ I give permission for the Board to transmit "live" images of my child (as part of a group) over the Internet via a web cam.
- ☐ I authorize and license the Board to post my child's class work on the Internet without infringing upon any copyright my child may own with respect to such class work. I understand only my child's first name will accompany such class work.

Parent/Guardian's Signature: _____ Date: _____

Student

I have read and agree to abide by the Student Network and Internet Acceptable Use and Safety Policy and Guidelines. I understand that any violation of the terms and conditions set forth in the Policy and Guidelines is inappropriate and may constitute a criminal offense. As a user of the Board's computers/network and the Internet, I agree to communicate over the Internet and the Network in an appropriate manner, honoring all relevant laws, restrictions and guidelines.

Student's Signature: _____ Date: _____

Teachers and building principals are responsible for determining what is unauthorized or in appropriate use. The principal may deny, revoke or suspend access to the Network/Internet to individuals who violate the Board's Student Network and Internet Acceptable Use and Safety Policy and related Guidelines, and take such other disciplinary action as is appropriate pursuant to the Student Code of Conduct.

Mohawk School Emergency Medical Authorization Form

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 parent or guardians cannot be reached.

Student Name_____ **Grade**_____

Address (PO BOX #) _____ **Zip**_____ **Date of Birth**_____

Home Phone _____ **Cell Phone** _____ **Email Address** _____

Mother's Name_____ **Day Time Phone**_____ **Place**_____

Father's Name_____ **Day Time Phone**_____ **Place**_____

Other adult to whom the child can be released (if additional space is needed, please use back)

Name_____ **Day Time Phone**_____ **Place**_____

Address_____ **Zip**_____ **Relationship**_____

Part 1 or Part 2 must be completed

Part 1- To Grant Consent

I hereby give consent for the following medical providers and local hospital to be called. 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 the below named doctors, or, in the event 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 physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Physician_____ **Phone**_____
Dentist_____ **Phone**_____
Medical Specialist_____ **Phone**_____
Hospital_____ **Phone**_____

Medical Alerts: (allergies, medications being taken and any physical impairment to which a physician should be alerted)

_____

X_____ X_____
Parent/Guardian Signature **Date**

Part 2- Refusal of Consent

I **DO NOT** give my consent for emergency medical treatment of any kind for my child. In the event of emergency treatment is needed, I wish the authorities to take the following action:_____

X_____ X_____
Parent/Guardian Signature **Date**

Permission to Use Student Image and Receipt of Handbook for grades K-12 (Grades K-12)

My signature acknowledges receipt and awareness of the contents of the student handbook and policies held within the Handbook. I grant permission for the use of my child's name to be used with their image or likeness in school publications, videos and web site

X_____ X_____ X_____ X_____
Parent/Guardian Signature **Date** **Student Signature** **Date**

Athletes-Complete both sides and return with the physical examination form before the first practice of your season.

Insurance Information

My son/daughter is covered by the insurance policy listed below in case of injuries received while participating in athletics.

Insurance Company_____

Policy Number_____

Athletic Participation Contract

In signing this contract, I am indicating that I have read the policies adopted by the Athletic Council, understand those policies fully, and do agree to abide by the policies. I also understand the penalties which may be assessed and my rights under the policies.

OHSAA Athletic Eligibility Information Bulletin

I have read the entire OHSAA Athletic Eligibility Information Bulletin and have had the opportunity to review its contents with school administrators if I wished to do so. I understand the information contained within this bulletin, and I realize that I will be expected to fulfill my responsibilities in compliance with the rules set forth.

I have read and agree to the above polices while my student athlete is in season.

X_____ _____
Athlete Signature **Date**

X_____ _____
Parent/ Guardian Signature **Date**

Ohio School Health Record
Physician's Report

Child's Name | Sex ☐ Male ☐ Female | Age | Date

Objective Data

Height (%) | Weight (%) | B.P. /

Screening Tests

Vision Date | Hearing Date

Distance Acuity	Right	Left		Pure tone testing:		
Muscle Balance	☐ pass	☐ fail	☐ not done	Right ear	☐ pass	☐ fail ☐ not done
Farsightedness	☐ pass	☐ fail	☐ not done	Left ear	☐ pass	☐ fail ☐ not done
Color	☐ pass	☐ fail	☐ not done	Other tests (specify)		
Child wears glasses?	☐ yes	☐ no				
Tested with glasses?	☐ yes	☐ no		Child wears hearing aid?	☐ yes	☐ no
Referral made?	☐ yes	☐ no		Tested with hearing aid?	☐ yes	☐ no
				Referral made?	☐ yes	☐ no

Speech/Language

Speech assessment ☐ done ☐ not done ☐ child has no discernible speech problem

Child has possible problem with: ☐ articulation ☐ Rhythm ☐ Voice ☐ Language

Speech evaluation recommended ☐ yes ☐ no

Laboratory Tests

☐ Hematocrit/Hemoglobin ☐ Urine protein ☐ Urine blood ☐ urine glucose ☐ other

Physical Examination:

Date examined:

☐ Essentially normal Abnormalities as follows:

Is this child able to participate fully in the following?

Classroom / Academic activity	☐ yes	☐ no	Competition athletics	☐ yes	☐ no
Physical Education classes	☐ yes	☐ no	Contact / Collision sports	☐ yes	☐ no

If limitations are advised, please specify:

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

Immunizations

DPT	/ /	/ /	/ /	/ /	/ /	/ /
TD	/ /	/ /	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /	/ /	/ /
Measles (Rubeola)	/ /	/ /				
Rubella	/ /	/ /				
Mumps	/ /	/ /				
MMR Combined	/ /	/ /				
Heb B Series	/ /	/ /	/ /	/ /	/ /	/ /
Varicella	/ /	/ /	/ /	/ /	/ /	/ /

Physician's Assessment

Problem

Recommendation for school management

Physician's Name

Date

Address

Phone

Physician Signature

Ohio School Health Record
Dentist's Report

The following services have been performed:

- ☐ Examination
- ☐ Diagnosis
- ☐ Radiographs
- ☐ Oral Prophylaxsis
- ☐ Prescription for fluoride supplements
- ☐ Topical application of fluoride

The following oral hygiene instruction was provided:

- ☐ Toothbrushing
- ☐ Flossing
- ☐ Diet counseling reflecting relation of diet to dental health
- ☐ Home / school use of fluoride mouthrinse

The following statements are applicable:

- ☐ All necessary services have been performed
- ☐ No restorative services are required at this time
- ☐ Further treatment is indicated
- ☐ Further appointments have been arranged

Comments: _____

Dentist's Name _____ **Date** _____

Address _____

Phone _____ **Dentist's Signature** _____

Ohio School Health History
[to be completed by parent or guardian]

Child's First – Middle – Last Name _____ Birth Date – Month – Day – Year _____

□ Male □ Female

Child's Address (include P.O. Box if applicable) _____

Father's Name – Address – Home Phone – Cell Phone – Work Phone _____

Mother's Name – Address – Home Phone – Cell Phone – Work Phone _____

With whom does child live? _____ Who is this child's legal guardian? _____

Family History – Please list child's brothers and sisters

Name	Birth Year	Sex	Name	Birth Year	Sex

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy?

□ Yes □ No If yes, explain briefly _____

How old was the mother when this child was born? _____ Was this infant born? □ full term □ early □ late What was this infant's birth weight? _____

Did the infant have any illness or problems while in the nursery?

□ Yes □ No If yes, explain briefly _____

Developmental History

Please give the approximate age at which this child:

□ Walked alone _____ □ Spoke in sentences _____ □ Was toilet trained _____ □ dressed self _____

How does this child's development compare to other children, such as his or her brothers/sisters or playmates?

□ About the same □ Slower □ Faster

Please check any that this child has had:

□ Abnormal spinal curvature (scoliosis, etc.)
□ Bedwetting at night
□ Chicken Pox
□ Cystic Fibrosis
□ Ear problems, poor hearing
□ Frequent sore throat infections
□ Measles (old fashioned or ten day)
□ Nervous twitches or tics
□ Seizures or epilepsy
□ Suicide attempt
□ Allergies or hayfever
□ Behavior problems
□ Chronic diarrhea or constipation
□ Diabetes
□ Eye problems, poor vision
□ Heart disease, type _____
□ Meningitis or encephalitis
□ Poisoning
□ Sickle cell disease
□ Toothaches or dental infections
□ Anemia
□ Birth or congenital malf.
□ Concern about relation with siblings or friends
□ Eczema
□ Frequent headaches
□ Hepatitis
□ Mumps
□ Pregnancy
□ Stool soiling
□ Urinary tract infection
□ Asthma or wheezing
□ Cancer, type _____
□ Emotional
□ Frequent skin infections
□ Kidney disease, type _____
□ Near-drown'g / suffocation
□ Rheumatic Fever
□ Substance abuse
□ Wetting during day

Allergies – List and describe allergies or reactions:

Medicine / Drugs _____

Foods / Plants / Animals / Other _____

Recommended treatment _____

Injuries and Illnesses – List any that were severe:

	Age of child	Check if hospitalized

Additional Information

Does child always wear seatbelts in cars? □ Yes □ No

Medications taken on a daily basis? _____

Medications given occasionally? _____

Do you have concern about how your child gets along with other children? _____

Is you child usually □ very active □ normally active □ rather inactive

Other comments or concerns _____

Completed by: _____ Relationship to child: _____