Kindergarten student

A copy of the following is needed:
Birth Certificate
Immunization Record
Vision/Hearing Testing

BEAR LAKE SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION PERMIT

Grade ________

Name | Date of Birth | Sex | Telephone No.

Number & Street | City | State | Zip Code

Mother's Name (Guardian) | Father's Name (Guardian)

Mother's Employment | Telephone No. | Father's Employment | Telephone No.

Family Physician | Address | Telephone No.

Family Dentist | Address | Telephone No.

Insurance Company | I.D. No.

Important Medical Information: Please list allergies, known drug reactions, current prescribed medication/treatments, and previous operations or hospital confinements. ____

Whenever my child is involved in a school activity and I am unavailable or otherwise unable to provide authorization directly, I grant to the school principal or his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnosis, and treatment, including surgical intervention, if necessary, on behalf of my minor child listed above and to do all other necessary things as I might or could do to provide for the child's health and safety, if I were present. This authorization is valid for the current school year or until such time as I withdraw the authorization.

Authorized ______________________________ Date ____________________
Parent/Guardian

Date: ____________

BEAR LAKE SCHOOLS
STUDENT ENROLLMENT FORM

2019-2020

Student Name: ____

Last First Middle

Township of student's residence: () Bear Lake () Pleasanton () Other__________________ **Citizenship:**________________

Grade: ___ **Sex:** ___ **Primary e-mail address:** ______________________________

Ethnic Background: () Amer. Indian () Black () Asian () Hispanic () Native Hawaiian or Other Pacific Islander () White, or () Two or More Races
Is the student's native tongue a language other than English:_______ **Is a language other than English spoken in the student's home or environment?**__________

Is this student Hispanic/Latino? (choose only one) **No, not Hispanic/Latino Yes, Hispanic/Latino** (A person of Cuban. Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Birthdate: ___/___/___ **Birthplace:** ________________________

Mo/Day/Yr City/State/Country

Last School Attended: ______________________________ **Address:**______________________________

Student's Residence is:

- ◻ With parent(s)/legal guardian & **does not** share a house, apartment, or mobile home w/ relative or another family
- ◻ With parent(s)/legal guardian & **does share** a house, apartment, or mobile home w/ relative or another family
- ◻ With parent(s)/legal guardian in a shelter or transition home
- ◻ With parent(s)/legal guardian in a motel, car, or campsite
- ◻ With grandparents, friends, etc. ◻ Other (Such as foster placement, etc.)

Migrant (seasonal student): () Yes () No **Has had Chickenpox:** () Yes () No

Received Special Services: () Yes () No **If yes, what type of service?**______________________________

Parents Marital Status: () Single () Married () Separated () Divorced () Widowed

Custody of Child is with: () Mother () Father () Mother/Father () Guardian

Non-custodial parent to receive communications from school: () Yes () No **Receive report cards:** () Yes () No

PARENTAL/GUARDIAN INFORMATION

	Mother	Father
Name(s):	____________________	____________________
Address: P.O. Box	____________	P.O. Box____________
Street:	____________________	____________________
City:	____________________	____________________
Telephone:	____________________	____________________

In case parent/guardian cannot be contacted, please list by priority who you want the school to contact:

Name	Relationship	Telephone
________________	____________________	__________
________________	____________________	__________
________________	____________________	__________

In the event of an emergency or early dismissal of school, my child is to go:

HOME:____________ OTHER:____

Name Address

Please avoid calling the school when an early dismissal occurs since most of the school's phone lines will be tied up with the dismissal. You may, of course, pick your child up at the time of dismissal.

/rsm

rev. 4/9/18

____

Signature of Parent/Guardian

SECTION III -- PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS

EXAMINATIONS AND/OR INSPECTIONS

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

TESTS AND MEASUREMENTS

		Normal	Under Care	Referred			Normal	Under Care	Referred
Vision Tested? ☐ Yes ☐ No Date______	☐ Visual Activity ☐ Ocular Muscle ☐ Other______				Urinalysis Done? ☐ Yes ☐ No Date______	☐ Sugar ☐ Albumin ☐ Microscopic			
Hearing Tested? ☐ Yes ☐ No Date______	☐ Audiometer ☐ Other______				Blood Pressure Measured? ☐ Yes ☐ No Reading______				
Hemoglobin/Hemotocrit Tested? ☐ Yes ☐ No					Height______ Other:	Weight______			
Blood Lead Level Tested? ☐ Yes ☐ No Date______	Reading______				Blood Lead level recommended for all children age six and under				

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

Tuberculin Test (if given) Date ______ Type______ ☐ Negative ☐ Positive ______ mm.

SECTION IV -- RECOMMENDATIONS

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other action? ☐ Yes ☐ No

If yes, please explain:

Should the student's activity be restricted because of any physical defect or illness? ☐ Yes ☐ No If yes, check below and explain degree of restriction:

☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Camp ☐ Other

Examiner's Signature	Date	Examiner's Name (print or type)	Degree or License
Number & Street	City	Zip	Telephone

SECTION V -- DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined ______ teeth and make the following recommendations as for treatment:

Child's Name

Dentist's Signature Date

COMMENTS

MDCH/OCAL-3305 Revised 2-2005

SECTION III -- PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS

EXAMINATIONS AND/OR INSPECTIONS

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

TESTS AND MEASUREMENTS

	Normal	Under Care	Referred		Normal	Under Care	Referred
Vision Tested? ☐ Yes ☐ No Date______ ☐ Visual Activity ☐ Ocular Muscle ☐ Other______				Urinalysis Done? ☐ Yes ☐ No Date______ ☐ Sugar ☐ Albumin ☐ Microscopic			
Hearing Tested? ☐ Yes ☐ No Date______ ☐ Audiometer ☐ Other______				Blood Pressure Measured? ☐ Yes ☐ No Reading______			
Hemoglobin/Hemotocrit Tested? ☐ Yes ☐ No				Height______ Weight______ Other:			
Blood Lead Level Tested? ☐ Yes ☐ No Date______ Reading______				Blood Lead level recommended for all children age six and under			

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

Tuberculin Test (if given) Date ______ Type______ ☐ Negative ☐ Positive ______ mm.

SECTION IV -- RECOMMENDATIONS

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other action? ☐ Yes ☐ No

If yes, please explain:

Should the student's activity be restricted because of any physical defect or illness? ☐ Yes ☐ No If yes, check below and explain degree of restriction:

☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Camp ☐ Other

Examiner's Signature | Date | Examiner's Name (print or type) | Degree or License

Number & Street | City | Zip | Telephone

SECTION V -- DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined ______ teeth and make the following recommendations as for treatment:

Child's Name

Dentist's Signature | Date

COMMENTS

Preschool Information

Did your child attend a 4-year-old program preschool? ☐ Yes ☐ No

Preschool Name:

- ☐ Great Beginnings Bear Lake
- ☐ GSRP Four Stars Brethren
- ☐ GSRP Madison Manistee
- ☐ Head Start Kaleva
- ☐ Head Start Manistee
- ☐ ISD Preschool
- ☐ Leaps & Bounds Onekama
- ☐ Manistee Area Public School
- ☐ MCC
- ☐ Trinity Lutheran
- ☐ Out of county preschool
- ☐ Other

Preschool Type:

- ☐ GSRP Head Start/GSRP Blend
- ☐ Head Start
- ☐ School Tuition
- ☐ Non Public Tuition
- ☐ Other

Preschool Day:

- ☐ Full Day – every day
- ☐ Half Day – every day
- ☐ Full Day – 4 days a week
- ☐ Half Day – 4 days a week
- ☐ Full Day – less than 4 days a week
- ☐ Half Day – less than 4 days a week
- ☐ Other

Repeated 4-year-old program? ☐ Yes ☐ No

Attended only a partial year 4-year-old program? ☐ Yes ☐ No

Did your child attend a 3-year-old program preschool? ☐ Yes ☐ No

Preschool Name:

- ☐ Great Beginnings Bear Lake
- ☐ GSRP Four Stars Brethren
- ☐ GSRP Madison Manistee
- ☐ Head Start Kaleva
- ☐ Head Start Manistee
- ☐ ISD Preschool
- ☐ Leaps & Bounds Onekama
- ☐ Manistee Area Public School
- ☐ MCC
- ☐ Trinity Lutheran
- ☐ Out of county preschool
- ☐ Other

Preschool Type:

- ☐ GSRP Head Start/GSRP Blend
- ☐ Head Start
- ☐ School Tuition
- ☐ Non Public Tuition
- ☐ Other

Preschool Day:

- ☐ Full Day – every day
- ☐ Half Day – every day
- ☐ Full Day – 4 days a week
- ☐ Half Day – 4 days a week
- ☐ Full Day – less than 4 days a week
- ☐ Half Day – less than 4 days a week
- ☐ Other

Repeated 3-year-old program? ☐ Yes ☐ No

Attended only a partial year 3-year-old program? ☐ Yes ☐ No

/rsm

AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

____________________________ ____________________________
Name of Student Address

____________________________ ____________________________
School Grade

A. I am requesting permission for my child named above to: (check all that apply)

- _____ Use or receive prescribed medication
- _____ Receive prescribed treatment
- _____ Self-administer prescribed medication(s) in my presence or that of an authorized staff member in accordance with the Doctor's prescription

B. I or a responsible adult will assume safe delivery of the medication to school

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

E. I will count the number of pills in the bottle and register the number with the school upon delivery.

____________________________________ __________________
Signature of Parent/Guardian Date

____________________________________ __________________
Home Telephone Work Telephone