

Black River Local School District How to Enroll

You will need the following with you when you enroll your child:

- / Copy of Your Child's Original Birth Certificate
- / Proof of Residency (See reverse side of this sheet for specific information.)
- / Custody Papers (If applicable)
- / Your Child's Social Security Card
- / Copy of Your Child's IEP/MFE for Special Education Purposes (If Applicable)
- / Copy of Your Child's Immunization Records, which must include the following:

- **Diphtheria, Tetanus, and Pertussis Vaccination:** 5 doses of DTaP, DTP, or DT or any combination, if the fourth dose was administered prior to the 4th birthday.
- **Polio Vaccination:** 3 or 4 doses of IPV, the final dose must be administered on or after the 4th birthday regardless of the number of previous doses; 4 doses if a combination of OPV and IPV was administered.
- **Measles, Mumps, and Rubella Vaccination:** 2 doses of MMR. The first doses must be administered on or after the first birthday. The second dose must be administered at least 28 days after the first dose.
- **Hepatitis B Vaccination:** 3 doses of Hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the series (third or fourth dose), must not be administered before age 24 weeks.
- **Varicella (Chickenpox) Vaccination:** 2 doses of Varicella (Chickenpox) vaccine must be administered prior to entry.

In the event the family is building or purchasing a home in the district, then the parent must provide the district with a sworn statement indicating the location of the house and the parent's intent to reside there, together with a statement from the builder (in the case of purchasing a home). This exception is not to exceed a period of 90 days.



Black River Local School District

Proof of Residence Requirement

Change of Residence, New Registration, or Re-Enrollment Registration

All parent(s) and guardian(s) **MUST** provide PROOF OF RESIDENCE in order to register their child/children in the Black River Local School District. The requirement includes all current residents within the Black River Local School District as well as families moving into the district.

All items submitted must include name and full address of parent(s)/guardian(s) and be current. Documents with post office addresses will not be accepted. **ONLY** the following legal documents will be accepted:

- ✧ Deed
- ✧ Mortgage Statement
- ✧ Building Permit
- ✧ Rental Agreement
- ✧ Property Tax Statement
- ✧ Voter Registration Card - Current
- ✧ Utility Bill - Current

Any student without an appropriate PROOF OR RESIDENCE record will be admitted under for a fourteen(14) day temporary enrollment period, unless extended by the superintendent, however, the student will not be officially registered in Black River Local School District. Class assignments or schedules will be provisional until the student is legally registered with an acceptable form of PROOF OF RESIDENCE.

The PROOF OF RESIDENCY requirement is in compliance with Ohio Revised Code* and Ohio Administrative Code** and is aligned to the Black River Local School District's Board of Education Bylaws and Policies Guidelines (5111). The requirement is not subject to interpretation. Utility bills will no longer be accepted.

The above documents must contain the names, address and phone number of the issuing person, business, or governmental agency as well as the residential parent(s)/guardian(s) name, address and phone number.

Parent(s)/guardian(s) should black out all account, balances, and other personal information. A copy of an original document will be provided for the parent to black out if necessary. All original documents will be returned.

If you have questions, concerns, or need to set up an appointment please call 419.736.3300.

*R.C. 2152.18, 3313.48, 3313.533, 3313.64, 3313.645, 3313.649, 3313.65, 3313.65, 3313.66, 3313.672, 3313.90, 3313.97, 3313.98, 3313.08, 3317.081, 3321.01(B), 3321.03, 3323.141, 3327.04, 3327.05, 3327.06, 5139.05

**A.C. 3301-42-01

Black River Local School District Cumulative Record Registration Form

Information supplied on this form is required under provisions of Ohio Law and the Ohio Department of Education. It is in no way an effort to trespass upon the personal affairs of parents.
Your cooperation in completing this form is appreciated.

For Office Use Only	
Registration Date	_____
Start Date	_____
Home School	_____
Attending School	_____
Student ID No.	_____ Date _____
Disability Code	_____

I affirm that the information below is correct and give permission to verify residence, if necessary.

Custodial Parent/Guardian Signature _____

STUDENT INFORMATION

Has the student ever attended Black River Local Schools before? No Yes If yes, give year or grade _____

Student's legal name as shown on Birth Certificate:

First _____ Middle _____ Last _____

Nickname _____ Social Security Number _____

Date of Birth _____ Age _____ Gender (M/F) _____ Student Grade Level _____

Citizenship _____ (01-Dual, 02-Non-Resident, 03-Resident Alien, 04-U.S. Citizen, 99-Other)

Ethnicity _____ (A-Asian/Pacific Islander, B-Black/African American, H-Hispanic/Latino, I-American Indian, M-Multiracial, W-White)

Place of Birth _____ Country _____
(City, State)

Language Spoken at Home English Other (Please Specify) _____

Student's Home Address _____ City _____ Zip _____

Ohio County of Residence _____ Home Phone Number _____
(Include City / Zip Code) Unlisted

GUARDIAN / CUSTODIAL INFORMATION

Student lives with (Check all Applicable): Both Parents Mother Father Step Parent Other / Guardian
 Alternates between Parents Foster Parents

Legal Custody is with: Both Parents
 Shared Parenting (Custody Documents are on File)
 Mother Only (if parents were unmarried at time of birth O.R. 3109.042 Custody Rights of Unmarried Mother)
 Mother Only or Father Only (Custody Documents are on File)
 Other / Guardian - Please State Name and Relationship _____
(Custody Documents are on File)

Parents are: Married Parents still married, but separated, not divorced. No custody order exists
 Never Married Separated Divorced Mother Deceased Father Deceased

Student is a dependent of a: Member of the Active Duty Forces (Army, Navy, Air Force, Marine Corps or Coast Guard)
 Member of the National Guard (Army National Guard or Air National Guard)
 None of the above.

Father / Custodial Parent or Guardian	Mother / Custodial Parent or Guardian
Name _____	Name _____
Address _____ (Include City / State / Zip Code)	Address _____ (Include City / State / Zip Code)
Home Phone _____	Home Phone _____
Cell Phone _____	Cell Phone _____
Employer _____	Employer _____
Work Phone _____	Work Phone _____
Email Address _____	Email Address _____

Spouse of Custodial Parent	
Name _____	Cell Phone _____
Employer _____	Work Place _____

Person other than those listed on this form who are authorized to pick up student at school:

Name Relationship Phone

Name Relationship Phone

Child Care Used: Not Applicable Every Day Before School Every Day After School

Who is your Child Care provider?

Provider _____

Name Address Phone

EDUCATION DATA

Previous School Attended _____ School District _____
(including Pre-school, etc...)

Address City/State Phone

- Public School Private School Other – Charter, Community, etc... (Please Specify _____)
- Home School

Was your child receiving any Special Education / Intervention services? No Yes

If yes, please explain: _____

- Remedial Reading Remedial Math Speech IEP 504 Plan Occupational Therapy
- Physical Therapy

Other – Please Specify _____

Has your child ever repeated a grade? No Yes If yes, what grade? _____

Has your child ever been identified as Gifted/Talented? No Yes

Has your child ever participated in a Gifted/Talented program? No Yes

Please List the names of other children in the home:

Name Age School Grade

Name Age School Grade

Name Age School Grade

Name Age School Grade

Black River Local Schools
McKinney-Vento Intake Affidavit

Student's Name: _____ Date of Birth: _____

Age _____ Grade: _____

Parent/Guardian Name(s): _____

Address: _____

Siblings of Student: _____

Please answer the following questions:

- | | | |
|-----------------------------------------------------------------------------------------|---------|--------|
| 1. Is this student's home address a temporary living arrangement? | ___ Yes | ___ No |
| 2. Is this a temporary living arrangement due to loss of housing or economic hardship? | ___ Yes | ___ No |
| 3. Is this student in temporary or emergency foster care placement? | ___ Yes | ___ No |
| 4. As a student, are you living with someone other than your parents or legal guardian? | ___ Yes | ___ No |

If you answered YES to **any** of the above questions, please complete the remainder of this form.

If you answered NO to all of the above questions, you may stop here. **Proof of residency is required!**

-
1. Where is this student currently living? (Check box)
- In a motel/hotel – Name of motel/hotel: _____
 - In a shelter – Name of shelter: _____
 - Temporary/emergency foster care: _____
 - With another family in a house or apartment.
 - Moving from place to place.
 - In a location not designed for sleeping accommodations such as a car, park or campsite.
2. With whom does the student currently live? (Check box)
- Both parents
 - One parent (mark with parent) _____ Mother _____ Father
 - One parent and another adult (mark which parent) _____ Mother _____ Father
 - A relative (specify e.g. grandparent) _____
 - Friend or other adult (please identify) _____
3. At this time, what is the greatest need for your child? (check all that apply)
- | | | |
|---------------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> School supplies | <input type="checkbox"/> Help for academic improvement | <input type="checkbox"/> Help for behavior improvement |
| <input type="checkbox"/> Referral for food assistance | <input type="checkbox"/> Medical referral/immunizations | <input type="checkbox"/> Mental health/counseling referral |
| <input type="checkbox"/> Other – Please describe: _____ | | |

My signature below affirms the following: (1) the information I have provided on this form is true and accurate to the best of my knowledge or belief; (2) the same information, as well as other information that may identify my child(ren), may be shared without my consent with the community and governmental agencies pursuant to an interagency collaboration between this school district and (3) the same information, as well as other information that may identify my child(ren), may be shared without my consent with other BRLS staff members for a legitimate educational purpose. In addition, my signature affirms that I have received a copy of my rights under the McKinney-Vento law and I agree to allow BRLS staff to conduct screenings as part of the district's McKinney-Vento program.

Parent Signature: _____
BRLS Witness Signature: _____

Date: _____
Date: _____

BLACK RIVER LOCAL SCHOOL DISTRICT
257 A County Road 40 Sullivan, OH 44880-9732
419-736-3300 – (P) 419-736-3308 – (F)
REQUEST FOR RELEASE OF STUDENT RECORDS

To: _____ Date _____
Previous School, Institution, or Individual's Name

Address _____
Phone Number _____ Fax Number _____

Resident
 Open Enrolled
 Foster Placed

Request for Records of the Student Identified Below:

Student's Name: _____ Present Grade _____

Date of Birth: _____

The student listed above has enrolled into the Black River School District. You are authorized to release the records below:

- | | | |
|------------------------------------------------------|---------------------------------------------------------------|-----------------------------|
| _____ Grades/Transcript | _____ Medical/Immunization Records | _____ Birth Certificate |
| _____ IEP/MFE/ETR/504 | _____ KRA Results | _____ OAA Results |
| _____ Social Security Card | _____ Custody Papers | _____ Psychological Reports |
| _____ 3 rd Grade Guarantee (On/Off Track) | _____ Attendance Records and Absence Intervention Plan | |
| _____ End of Course Exam Results | _____ Next Generation Assessments | |

Please note, if you do not release special education records from your office, please make a copy of this release form and send it to the appropriate office. Thank You!

Please scan academic records to: records@blrv.org. Please note in subject line students name.

Please scan all Special Education records to: lbowling@blrv.org.

PARENT/GUARDIAN AUTHORIZATION FOR RELEASE

I hereby authorize the school, institution, or individual indicated above to release and/or provide access to the records checked above.

Signature _____ Date _____
Parent, Legal Guardian, or Adult Pupil

OFFICE USE ONLY

Signature _____ Title _____ Date _____
School Official

EMERGENCY MEDICAL AUTHORIZATION

CHECK HERE IF INFORMATION IS NEW

GRADE: _____ M: _____ F: _____



Student's Name: _____ Birth Date: _____

Address: _____ County: _____

City: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

Office Use Only:

Student Picture

Student Lives With (Circle all that Apply) Mother Father Stepparent Guardian Other: _____

Mother's Name: _____
Home #: _____
Cell #: _____
Work #: _____
Employer: _____
Mother active military: Yes _____ No _____

Father's Name: _____
Home #: _____
Cell #: _____
Work #: _____
Employer: _____
Father active military: Yes _____ No _____

Emergency Contacts – must have **THREE (3) working different numbers** who have the authority to make decisions in an emergency situation involving this student if we cannot contact the parent(s) or guardian(s) or have permission to release student to:

- 1. Name: _____ Home: _____ Work/Cell: _____ Relation: _____
- 2. Name: _____ Home: _____ Work/Cell: _____ Relation: _____
- 3. Name: _____ Home: _____ Work/Cell: _____ Relation: _____
- 4. Name: _____ Home: _____ Work/Cell: _____ Relation: _____

COMPLETE ONLY ONE OF THE FOLLOWING: Part I: Consent for Treatment OR Part II: Refusal to Consent

Part I: Consent for Treatment

I hereby give my consent for the following medical care providers and local hospital to be called when I cannot be contacted:

Doctor's Name: _____ Phone #: _____ Address: _____
Dentist's Name: _____ Phone #: _____ Address: _____
Medical Specialist's Name: _____ Phone #: _____ Address: _____

ALL STUDENTS WILL BE TRANSPORTED BY SULLIVAN EMT

Please circle the emergency room you would like your student transported to:

Lodi Community Hospital, Lodi Allen Medical Center, Oberlin Samaritan Hospital, Ashland

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 preferred doctor indicated, 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 medial opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Medical History: *Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment of which a physician and/or school personnel should be alerted:*

Parent/Guardian Signature: _____ 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:

Parent/Guardian Signature: _____ Date: _____

BLACK RIVER SCHOOL DISTRICT EMERGENCY SCHOOL CLOSING INFORMATION

In the event of an emergency school closing or an early dismissal, we would like to have the following information in order that the dismissal be efficient. Please complete this form and return it immediately to your child's homeroom teacher.

Student's Name	
Classroom Teacher (Grades K-5)	
Classroom Teacher (Grades 6-8)	
Homeroom Teacher(Grades 9-12)	
Student's P.M. bus number	

NO PHONE CALLS will be made in the event of Early Dismissal.

Please select from below:			
In the event of an early dismissal from school, I would prefer my child to:			
	Be transported on the same school bus and sent to the same destination as on a regular P.M. dismissal. (Your child should have access to gain safe entry into the home.)		
	Be transported to the following destination within the Black River School District:	Name:	
		Address:	
		Phone:	
	Walk home as usual.		
	Allow my child to drive home.		

Information will be broadcast through local radio stations including: **WEOL, WNCO, and WQMX.**

PLEASE DISCUSS this procedure with your child so that he/she has full knowledge of where he/she will be going in case of Early Dismissal. This information will be available to teachers and office personnel. Please sign your agreement below. Do not detach. Return entire sheet to the school immediately.



I grant permission to Black River Local Schools to dismiss and/or transport my child according to the choice indicated above in the event of an emergency. I have read and verified that the information above is correct.

Please return this sheet to the teacher listed above.

--	--

Signature of Parent/Guardian

Date

Thank you for taking the time to complete this form and return it.

BLACK RIVER LOCAL SCHOOL DISTRICT
STUDENT HEALTH HISTORY
To Be Completed by Parent/Guardian

This information is for school use only and will not be released to unauthorized persons.

Student's Name: _____ Date of Birth _____
Last First MI

Father's (or Guardian) Name: _____ Telephone: _____

Mother's (or Guardian) Name: _____ Telephone: _____

Child's Physician: _____ Telephone: _____

Child's Dentist: _____ Telephone: _____

Family Health History: (Tuberculosis, Diabetes, Asthma, Heart Disease...)

Medications: (Does your child take any medications on a regular basis? If so, please list and indicate which medication, if any, will be taken during the school day.)

Student's Health History: (Please include dates whenever possible.)

Chickenpox: Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy: Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes: Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma: Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Condition: Yes <input type="checkbox"/> No <input type="checkbox"/>
(Please Specify: _____)	Frequent Ear Infections: Yes <input type="checkbox"/> No <input type="checkbox"/>
Diagnosed Attention Deficit Disorder: Yes <input type="checkbox"/> No <input type="checkbox"/>	Bedwetting: Yes <input type="checkbox"/> No <input type="checkbox"/>
Diagnosed Hyperactivity (ADHD): Yes <input type="checkbox"/> No <input type="checkbox"/>	Speech/Language Concerns: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Other: _____

Vision History:

Has your child had a comprehensive eye exam? Yes No By Whom? _____

Glasses: Yes No When Prescribed? _____ By Whom? _____

List any special considerations needed: _____

Hearing History:

Has this child had a comprehensive hearing exam? Yes No By Whom? _____

Hearing Aid: Yes No When Prescribed? _____ By Whom? _____

List any special considerations needed: _____

RESTRICTIONS: (Please list any restrictions that may require special considerations including dietary.)

Signature of Parent/Guardian: _____ Date: _____

Immunization Summary for School Attendance Ohio

VACCINES	FALL 2017 IMMUNIZATIONS FOR SCHOOL ATTENDANCE
DTaP/DT Tdap/Td Diphtheria, Tetanus, Pertussis	<p>K Four (4) or more of DTaP or DT, or any combination. If all four doses were given before the 4th birthday, a fifth (5) dose is required. If the fourth dose was administered at least six months after the third dose, and on or after the 4th birthday, a fifth (5) dose is not required. *</p> <p>1-12 Four (4) or more of DTaP or DT, or any combination. Three doses of Td or a combination of Td and Tdap is the minimum acceptable for children age seven (7) and up.</p> <p>Grades 7-12 One (1) dose of Tdap vaccine must be administered prior to entry. **</p>
POLIO	<p>K-7 Three (3) or more doses of IPV. The FINAL dose must be administered on or after the 4th birthday regardless of the number of previous doses. If a combination of OPV and IPV was received, four (4) doses of either vaccine are required. ***</p> <p>Grades 8-12 Three (3) or more doses of IPV or OPV. If the third dose of either series was received prior to the fourth birthday, a fourth (4) dose is required; If a combination of OPV and IPV was received, four (4) doses of either vaccine are required.</p>
MMR Measles, Mumps, Rubella	<p>K-12 Two (2) doses of MMR. Dose 1 must be administered on or after the first birthday. The second dose must be administered at least 28 days after dose 1.</p>
HEP B Hepatitis B	<p>K-12 Three (3) doses of Hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the series (third or fourth dose), must not be administered before age 24 weeks.</p>
Varicella (Chickenpox)	<p>K-7 Two (2) doses of varicella vaccine must be administered prior to entry. Dose 1 must be administered on or after the first birthday. The second dose should be administered at least three (3) months after dose one (1); however, if the second dose is administered at least 28 days after first dose, it is considered valid.</p> <p>Grades 8-11 One (1) dose of varicella vaccine must be administered on or after the first birthday.</p>
MCV4 Meningococcal	<p>Grade 7-8 One (1) dose of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to entry.</p> <p>Grade 12 Two (2) doses of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to entry. ****</p>

NOTES:

- Vaccine should be administered according to the most recent version of the *Recommended Immunization Schedules for Persons Aged 0 Through 18 Years* or the *Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind*, as published by the Advisory Committee on Immunization Practices. Schedules are available for print or download at <http://www.cdc.gov/vaccines/recs/schedules/default.htm>.
- Vaccine doses administered ≤ 4 days before the minimum interval or age are valid (grace period). Doses administered ≥ 5 days earlier than the minimum interval or age are not valid doses and should be repeated as age-appropriate. If MMR and Varicella are not given on the same day, the doses must be separated by at least 28 days with no grace period.
- For additional information please refer to the Ohio Revised Code 3313.67 and 3313.671 for School Attendance and the ODH Director's Journal Entry (available at www.odh.ohio.gov, Immunization: Required Vaccines for Childcare and School). These documents list required and recommended immunizations and indicate exemptions to immunizations.
- Please contact the Ohio Department of Health Immunization Program at (800) 282-0546 or (614) 466-4643 with questions or concerns.

*Recommended DTaP or DT minimum intervals for kindergarten students four (4) weeks between doses 1-2 and 2-3; six (6) month minimum intervals between doses 3-4 and 4-5. If a fifth dose is administered prior to the 4th birthday, a sixth dose is recommended but not required.

** Pupils who received one dose of Tdap as part of the initial series are not required to receive another dose. Tdap can be given regardless of the interval since the last Tetanus or diphtheria- toxoid containing vaccine. DTaP given to patients age 7 or older can be counted as valid for the one-time Tdap dose.

*** The final polio dose in the IPV series must be administered at age 4 or older with at least six months between the final and previous dose.

**** Recommended MCV4 minimum interval of at least eight (8) weeks between dose one (1) and dose two (2). If the first (1st) dose of MCV4 was administered on or after the 16th birthday, a second (2nd) dose is not required. If a pupil is in 12th grade and is 15 years of age or younger, only 1 dose is required. Currently there are no school entry requirements for meningococcal B vaccine.



**ASHLAND COUNTY - CITY HEALTH DEPARTMENT
NURSING DIVISION**

1763 St. Rt. 60 • Ashland, Ohio 44805-8707

419-282-4357 419-282-4271 Fax

nursing@ashlandhealth.com

Daniel R. Daugherty, M.D., *Health Commissioner* Al Sanders, B.S., R.S., *Administrator*
Equal Opportunity Employer / Provider

TUBERCULOSIS SCREENING

Please answer the following questions to determine your risk of tuberculosis infection and the need for TB skin testing.

NAME: _____

D.O.B. _____

	<u>YES</u>	<u>NO</u>
Have you had close or prolonged contact with someone sick with tuberculosis or someone with a positive TB skin test?	_____	_____
Were you born in or did you live in Africa, Asia, Eastern Europe, South/Central America, or any countries of the former Soviet Union?	_____	_____
Have you traveled to any of the above countries within past 5 years?	_____	_____
Have you ever had a chest x-ray suggestive of inactive or past TB?	_____	_____
Have you been a resident or employee of a high-risk congregate setting? (such as correctional facility, nursing home, hospital, homeless shelter)	_____	_____
Are you taking any medication that your doctor said could suppress your immune system or make you prone to infection?	_____	_____
Have you ever used drugs not prescribed by a doctor? (such as marijuana, heroin, cocaine, including alcohol abuse)	_____	_____
Do you have any of the following medical conditions: <i>(please circle)</i> diabetes mellitus, silicosis, cancer of head or neck, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, organ transplant recipient, HIV infection, Hodgkin's disease, leukemia	_____	_____
Are you a health care worker who serves high-risk clients (see above)?	_____	_____
For children: has this child had <i>prolonged</i> exposure to anyone homeless, incarcerated, resident of a nursing home, user of illicit drugs, HIV patient, migrant farm worker?	_____	_____
Do you have any of these symptoms: bad cough for over 2 weeks, persistent fever, coughing up blood, excessive weight loss, fatigue, night sweats?	_____	_____

Please return this form to your employer or school.

Signature of patient/parent/guardian _____ Date _____

FORM ON BACK





**ASHLAND COUNTY- CITY HEALTH DEPARTMENT
NURSING DIVISION**

1763 St. Rt. 60 · Ashland, Ohio 44805-8707

419-282-4357 419-282-4271 Fax

nursing@ashlandhealth.com

Daniel R. Daugherty, M.D., Health Commissioner Al Sanders, B.S., R.S., Administrator
Equal Opportunity Employer / Provider

HISTORY OF VARICELLA (CHICKENPOX) DISEASE

_____ DOB ____/____/____
(Name of child)

had varicella (chickenpox) _____, and is therefore exempt from
(date or age)
the school varicella vaccine requirement due to natural immunity.

Signature parent/legal guardian _____ Date: _____



Black River Local Schools

2019-2020 Transportation Request Form

Date _____ Date of Birth: _____

Student's Name _____

First MI Last

Home Address _____

Home Phone # _____ Cell # _____ Emg # _____

School Of Attendance _____ Grade _____ AM PM

Medical Alert Driver should know: _____

Parent/Guardian Signature: _____

Morning Transportation - ONLY ONE LOCATION PERMITTED, UNLESS COURT-ORDERED SHARED PARENTING

- I will be providing transportation in the AM
- My child will attend Latchkey - needs no busing
- My child will need busing from our home address in the AM BUS #
- My child will need busing **EVERYDAY** from an alternate address in the AM
- Pre-Approved Transportation Request detailed below *** **MUST be approved in advance**

Alternate Address: _____

Child Care Provider: _____

Provider's Name	Phone #	Relationship
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Afternoon Transportation - ONLY ONE LOCATION PERMITTED, UNLESS COURT-ORDERED SHARED PARENTING

- I will be providing transportation in the PM
- My child will attend Latchkey - needs no busing
- My child will need busing to our home address in the PM BUS #
- My child will need busing **EVERYDAY** to an alternate address in the PM
- Pre-Approved Transportation Request detailed below *** **MUST be approved in advance**

Alternate Address: _____

Child Care Provider: _____

Provider's Name	Phone #	Relationship
-----------------	---------	--------------

Please complete and submit this form selecting the appropriate box for BOTH the AM pickup and PM drop off. One form required for EACH student. Only ONE pickup and ONE drop-off point is permitted per student. Schedule MUST be the same for all school days, unless prior arrangements have been made and approved!!

List any pre-approved transportation requests below:

Transportation Use Only:

Driver notified: _____ Entered into software: _____

Student ID: _____

Parent notified: _____ Initials: _____



Black River Local Schools

2019-2020 Transportation Request Form

Date _____ Date of Birth: _____

Student's Name _____

First MI Last

Home Address _____

Home Phone # _____ Cell # _____ Emg # _____

School Of Attendance _____ Grade _____ AM PM

Medical Alert Driver should know: _____

Parent/Guardian Signature: _____

Morning Transportation - ONLY ONE LOCATION PERMITTED, UNLESS COURT-ORDERED SHARED PARENTING

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- My child will need busing **EVERYDAY** from an alternate address in the AM
- Pre-Approved Transportation Request detailed below *** **MUST be approved in advance**

Alternate Address: _____

Child Care Provider: _____

Provider's Name	Phone #	Relationship
-----------------	---------	--------------

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Child Care Provider: _____

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Driver notified: _____ Entered into software: _____

Student ID: _____

Parent notified: _____ Initials: _____

