

## 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 4<sup>th</sup> birthday.
  - **Polio Vaccination:** 3 or 4 doses of IPV, the final dose must be administered on or after the 4<sup>th</sup> 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 \_\_\_\_\_ (City, State) \_\_\_\_\_ Country \_\_\_\_\_

Language Spoken at Home  English  Other (Please Specify) \_\_\_\_\_

Student's Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

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

### 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.

### THE AREA BELOW MUST BE COMPLETED

| Father or Custodial Parent or Guardian                            | Mother or Custodial Parent or Guardian                            |
|---|---|
| Name _____  | Name _____  |
| Address _____<br><small>(Include City / State / Zip Code)</small> | Address _____<br><small>(Include City / State / Zip Code)</small> |
| 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)
  - School supplies  Help for academic improvement  Help for behavior improvement
  - Referral for food assistance  Medical referral/immunizations  Mental health/counseling referral
  - 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: \_\_\_\_\_

Date: \_\_\_\_\_

BRLS Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**KINDERGARTEN REGISTRATION  
CONSENT FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_, give permission to the Black River Local  
Parent/Guardian  
School District to consult with the preschool my child attended and to obtain from  
or release to them necessary information concerning

\_\_\_\_\_  
(Student Name)

\_\_\_\_\_  
(Birthdate)

Please complete:

Preschool: \_\_\_\_\_

Address: \_\_\_\_\_

Preschool: \_\_\_\_\_

Address: \_\_\_\_\_

Reasons for release of information: The information will be used for planning the student's educational program and services.

Parent/Guardian Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Date signed: \_\_\_\_\_

My child did not attend preschool.

I do not want this information released.





**This form is to be completed by a parent or guardian registering a child for enrollment in the Black River Local School District.**

Dear Parent:

To provide a continuous educational program for your child, we need to know what services your child has at his/her previous school.

Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Age: \_\_\_\_\_

My child was involved in:

| <u>AREA</u>           | <u>YES</u> | <u>NO</u> |
|-----------------------|------------|-----------|
| Speech Therapy        | _____      | _____     |
| Occupational Therapy  | _____      | _____     |
| Physical Therapy      | _____      | _____     |
| Resource Room         | _____      | _____     |
| Title I (Math)        | _____      | _____     |
| Title I (Reading)     | _____      | _____     |
| Current IEP           | _____      | _____     |
| Disability Category   | _____      | _____     |
| Gifted Identification | _____      | _____     |
| Served on a WEP       | _____      | _____     |
| Other: _____          | _____      | _____     |

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**2021-2022 EMERGENCY MEDICAL AUTHORIZATION FORM**

Student Name: \_\_\_\_\_ Grade \_\_\_\_\_

LAST

FIRST

Address: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Custody Information/Lives with: \_\_\_\_\_

**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. Allow others to pick-up child from school when needed.

**Call Order**

\_\_\_\_ Mother/Guardian: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Address: (if different from students) \_\_\_\_\_

Email Address: \_\_\_\_\_

Activity Military:  Yes  No Employer: \_\_\_\_\_

\_\_\_\_ Father/Guardian: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Address: (if different from students) \_\_\_\_\_

Email Address: \_\_\_\_\_

Activity Military:  Yes  No Employer: \_\_\_\_\_

\_\_\_\_ Other's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Relation: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_ Other's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Relation: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_ Other's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Relation: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**\*\*\*FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED:**

**Part 1 OR Part 2 MUST BE COMPLETED Do not complete both sections**

**PART 1 - 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: \_\_\_\_\_

Please circle the emergency room you would like your student transported to: (All students will be transported by Sullivan/Spencer Rescue): **Lodi Community Hospital, Lodi Allen Medical Center, Oberlin UH Samaritan, 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.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PART II - TO REFUSE 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 Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**REVERSE SIDE MUST BE COMPLETED**



The Ohio Department has required the Black River Local School District to report the following information starting with the 2020-2021 school year:

- Does the student have Internet Connectivity: \_\_\_Yes \_\_\_No
- What Internet Provider? \_\_\_\_\_
- What is the bandwidth of your home internet? (5G, 4G, 3G, \_\_\_MBPS, etc.) \_\_\_\_\_
- Does the students have access to a device at home? \_\_\_Yes \_\_\_No

## BLACK RIVER LOCAL SCHOOLS 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: \_\_\_\_\_

Grade: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_

**Parents will be notified via the districts One Call systems of any early dismissals.**

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 dismissal.  
(Your child should have access to gain safe entry into the home.)

\_\_\_\_\_ Be transported to the following destination within the Black River Local School District:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_ Allow my child to drive home. **(For high school students only)**

Please discuss this procedure with your child so that he/she has full knowledge of where he/she will be going in case of an early dismissal. This information will be available to teachers and office personnel.

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.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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/Guardian Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Child's Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

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

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

Chickenpox:  Yes  No

Epilepsy:  Yes  No

Diabetes:  Yes  No

Asthma:  Yes  No

Allergies:  Yes  No

Frequent Ear Infections:  Yes  No

(Please specify: \_\_\_\_\_)

Bedwetting:  Yes  No

Diagnosed Attention Deficit Disorder:  Yes  No

Speech/Language Concerns:  Yes  No

Diagnosed Hyperactivity (ADHD):  Yes  No

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 your 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: \_\_\_\_\_



## VACCINES

## FALL 2020 Immunizations for School Attendance

|  |   |
|--|---|
| <p><b>DTaP/DT Tdap/Td</b><br/>Diphtheria, Tetanus, Pertussis</p> | <p><b>Kindergarten</b><br/>Four (4) or more doses of DTaP or DT, or any combination. If all four doses were given before the fourth birthday, a fifth (5th) dose is required. If the fourth dose was administered at least six months after the third dose, and on or after the fourth birthday, a fifth dose is not required. *</p> <p><b>Grades 1-12</b><br/>Four (4) or more doses of DTaP or DT, or any combination. Three doses of Td or a combination of Td and Tdap is the minimum acceptable for children ages 7 and older, with proper spacing.</p> <p><b>Grades 7-12</b><br/>One (1) dose of Tdap vaccine must be administered on or after the 10<sup>th</sup> birthday. **</p> |
| <p><b>POLIO</b></p>  | <p><b>K-10</b><br/>Three (3) or more doses of IPV. The FINAL dose must be administered on or after the fourth 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><b>Grades 11-12</b><br/>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<sup>th</sup>) dose is required; if a combination of OPV and IPV was received, four (4) doses of either vaccine are required.</p>  |
| <p><b>MMR</b><br/>Measles, Mumps, Rubella</p>                    | <p><b>K-12</b><br/>Two (2) doses of MMR. Dose one (1) must be administered on or after the first birthday. The second (2<sup>nd</sup>) dose must be administered at least 28 days after dose one (1).</p>   |
| <p><b>HEP B</b><br/>Hepatitis B</p>                              | <p><b>K-12</b><br/>Three (3) or (4) 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 eight weeks after the second dose. The last dose in the series (third or fourth dose) must not be administered before age 24 weeks.</p>  |
| <p><b>VARICELLA</b><br/>(Chickenpox)</p>                         | <p><b>K-10</b><br/>Two (2) doses of varicella vaccine must be administered prior to entry. Dose one (1) must be administered on or after the first birthday. The second dose should be administered at least three months after dose one (1); however, if the second dose is administered at least 28 days after the first dose, it is considered valid.</p> <p><b>Grades 11-12</b><br/>One (1) dose of varicella vaccine must be administered on or after the first birthday.</p>  |
| <p><b>MCV4</b><br/>Meningococcal</p>                             | <p><b>Grades 7-11</b><br/>One (1) dose of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to entry.</p> <p><b>Grade 12</b><br/>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 Schedule for Children and Adolescents Aged 18 Years or Younger* 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 [www.cdc.gov/vaccines/imz/downloads/index.html](#).
- 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 [Ohio Immunization Schedule for School Attendance](#) (available at [www.ohio.gov/immunization](#)). 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 fourth birthday, a sixth dose is recommended but not required.

\*\* Tdap can be given regardless of the interval since the last tetanus or diphtheria toxoid-containing vaccine. Children age 7 years or older with an incomplete history of DTaP should be given Tdap as the first dose in the catch-up series. If given at age 7-9 years, the routine Tdap dose at age 11-12 years should be given. If given at age 10 years, no additional dose is needed at age 11-12 years.

\*\*\* 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 (1<sup>st</sup>) dose of MCV4 was administered on or after the 16<sup>th</sup> birthday, a second (2<sup>nd</sup>) dose is not required. If a pupil is in 12<sup>th</sup> grade and is 15 years of age or younger, only one (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](mailto: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: \_\_\_\_\_

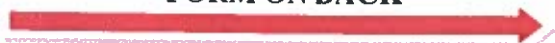
D.O.B. \_\_\_\_\_

|   | <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: \_\_\_\_\_

**This forms must be completed**





# Black River Local Schools 2021-2022 Transportation Request Form

Date \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student's Name \_\_\_\_\_

First MI Last

Home Address \_\_\_\_\_

Home Phone # \_\_\_\_\_

Cell # \_\_\_\_\_

Emg # \_\_\_\_\_

Parent Email Address: \_\_\_\_\_  
(this information is used for our Stopfinder app)

School Of Attendance \_\_\_\_\_

Grade \_\_\_\_\_

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

### 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:**

notified: \_\_\_\_\_ Entered into software: \_\_\_\_\_

Driver

Student ID: \_\_\_\_\_

Parent

notified: \_\_\_\_\_ Initials: \_\_\_\_\_



FOR STAFF USE:  
ASHA ASHJ ASHJR ASCHSC ASHTE ASHST ASHR (4ForU)  
ASBA ASBJ ASBJR ASBSC ASBTE ASBORMB

card# 1448000

Initials: \_\_\_\_\_

date: \_\_\_\_\_

## ASHLAND PUBLIC LIBRARY CARD APPLICATION

### Applicant Information & Address

|                               |               |                                   |
|-------------------------------|---------------|-----------------------------------|
| Legal Name: <i>first</i>      | <i>middle</i> | <i>last</i>                       |
| Preferred name:               | Select Pin #: | (1 - 8 letters and/or numbers)    |
| Birthdate <i>mm/dd/yyyy</i> : | Age:          | Gender <i>please circle</i> : M F |
| Street address & apt #:       | PO Box:       |                                   |
| City:                         | State:        | Zip:                              |
| Phone:                        |               |                                   |

### To Be Sent Hold/Overdue Notices By Email And/Or Text, Fill Out The Following:

|  |
|--|
| Hold/Notification Email:                       |
| Hold/Notification Text#: <i>@sms.oplin.org</i> |

### Information Required For Applicants Under The Age Of 18

*Signature also required at bottom of form*

|   |                |
|---|----------------|
| Printed name of parent/guardian:  | P/G birthdate: |
| <b>RESTRICTED ACCESS:</b> I Request That My Child, Who Is Under The Age Of 18, Be <b>DENIED</b> Access To Video Recordings. I Understand This Means Restricting Access To <b>ALL</b> Video Recordings Including DVDs And VHS Tapes. If Unchecked, Child Will Have <b>Unrestricted</b> Access. |                |

### Information Required For University Student Or 4forU Applicants

*Home address for student applicants; address listed on ID for 4forU applicants*

|                          |         |      |
|--------------------------|---------|------|
| Street address & apt. #: | PO Box: |      |
| City:                    | State:  | Zip: |

### Are You Interested In Registering For A Golden Buckeye Card?

*At the Ashland Public Library, Golden Buckeye card holders are exempt from daily overdue fines.*

Select if you are interested in a Golden Buckeye Card – or if you are a current card holder.

### APPLICANT AGREEMENT AND SIGNATURE

I agree to obey all of the rules and regulations of the ASHLAND PUBLIC LIBRARY and to promptly pay fines, fees, damage fees, and replacement costs charged against my account/minor's account for books and other library materials that are overdue, lost, or damaged. I acknowledge that if the ASHLAND PUBLIC LIBRARY turns my account over to a material recovery service, additional collection fees will be incurred.

|                               |       |
|-------------------------------|-------|
| Applicant's signature:        | Date: |
| Signature of parent/guardian: | Date: |

