**National Trail Local School District**
**6940 Oxford Gettysburg Road**
**New Paris, Ohio 45347**
**Telephone – (937) 437-3333**
**Fax – (937) 437-7306**

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August, 2017

Dear Parents/Guardians,

**Please return the attached forms to your child's homeroom teacher by September 1, 2017.**
**Please fill out the forms completely- including signatures, dates, and student grade.**

We have provided you with the following checklist to explain the necessary forms.

_______ Annual Pupil Registration Information. Current registration information must be taken each year (back of emergency medical)

_______ Emergency Medical Authorization. It is very important that we have contact people and telephone numbers to care for your child if he/she becomes ill or is injured.(back of registration form)

_______ Student Directory Information Non-Release Form (back of Handbook Agreement).

_______ **Student Handbook Agreement.** Please read through the handbook with your child **(located in the front of your child's student planner)** so that all of you will be familiar with rights and responsibilities of the school and your National Trail student (back of directory information)

_______ Student Health Form: Grades K, 3rd, 5th & 9th. To better serve your child at school, we need updated information related to their health. Remember to notify the school if there are any changes throughout the school year

_______ For elementary students only if your child will be picked up or dropped off at another location other than their home address please fill out the alternate bus transportation form.

**Thank you for completing, signing, and returning the required forms. We realize that this job is somewhat overwhelming and bothersome, but we must comply with state guidelines, and have on file current and accurate information for the safety and well-being of your child.**

**National Trail Staff**

STUDENT NUMBER ____________
*For Office Use Only*

**NATIONAL TRAIL LOCAL SCHOOL DISTRICT**
**ANNUAL PUPIL REGISTRATION INFORMATION**
**SCHOOL YEAR 2017 – 2018**

**LEGAL NAME OF PUPIL:**________________________________________**SEX:**________**GRADE:**____________
Last First Middle

**DATE OF BIRTH**_____ /_____/_______ **SOCIAL SECURITY NUMBER:**______________________________

**PLACE OF BIRTH**________________________________**ATTENDED OHIO SCHOOL BEFORE?** _____ **YES** _____**NO**
City County State

**NAME AND ADDRESS OF SCHOOL LAST ATTENDED (IF NEW TO DISTRICT):**____________________

**CHECK THOSE WHICH APPLY:**
**Marital Status:**
( ) **MARRIED** ( ) **SEPARATED** ( ) **DIVORCED**
( ) **SINGLE PARENT** ( ) **FATHER DECEASED**
( ) **MOTHER DECEASED**
( ) **OTHER** ______________________________

***What is the Ethnic Origin of Pupil*? (Choose One)**
**Hispanic/Latino**____________ **Non-Hispanic**___________
**If student is Non-Hispanic please check one (or more) of the following:**
____ Alaskan Native or American Indian ____ Asian
____ Black or African American _____ Native Hawaiian
_____White (or Other Pacific Islander)
**(Please note: failure to complete this section will result in a district determination of ethnicity)**

**FATHER'S NAME:**________________________________________________________________________

**PARENTAL MILITARY STATUS**: NONE: _________ ACTIVE DUTY: __________ BRANCH:________________________

**HOME PHONE:**______________________ ACTIVE RESERVE: _______________ BRANCH: ________________________

**ADDRESS:**______________________________________________________________________________
Street Address PO Box City State Zip

**E-MAIL ADDRESS:**____________________________________ **CELL NUMBER:**__________________________________

**PLACE OF EMPLOYMENT**:______________________________**WORK PHONE:**__________________________________

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**MOTHER'S NAME:**_____________________________________**MOTHER'S MAIDEN NAME:**______________________

**PARENTAL MILITARY STATUS:** NONE: ___________ ACTIVE DUTY: ________________BRANCH:__________________

**HOME PHONE**________________________ACTIVE RESERVE: ____________BRANCH:____________________________

**ADDRESS:**______________________________________________________________________________
Street Address PO Box City State Zip

**E-MAIL ADDRESS:**____________________________________ **CELL NUMBER:**__________________________________

**PLACE OF EMPLOYMENT:**______________________________ **WORK PHONE:** ________________________________

**PARENT/PERSON(S)/GOVERNMENTAL AGENCY HAVING LEGAL OR PERMANENT CUSTODY OF PUPIL: For any student not living with both biological parents, proof of custody is required at the time of enrollment. A copy of your divorce decree or award of separation listing custodial status must be presented and photocopied by the building secretary. If the custody determination is pending, a letter from the court or your attorney is required stating the anticipated date of such action.** Custodial Status Verification: ________

***NAME:***_______________________________________________ ***RELATIONSHIP TO PUPIL:***______________________________

***ADDRESS:***____________________________________________________________________________________
*Street Address City State Zip*

***HOME PHONE:***___________________________________***WORK PHONE:*** ______________________________________

***SPECIAL EDUCATION or SERVICES***

**Is child on an IEP or receiving any special services?** ________ **Yes** ________**No If yes please indicate number from the list below:** ___________
**(1) Multiple disabilities (2) Deaf-Blindness (3) Deafness (hearing impairment (4) Visual Impairment (5) Speech or Language Impairment (6) Orthopedic Impairment (7) Emotional Disturbance (8) Cognitive Disabilities (9) Specific Learning Disability (10) Preschooler with a Disability (11) Autism (12) Traumatic Brain Injury (13) Other Health Impairment**

PERSON OTHER THAN THE PARENTS TO CONTACT IN CASE OF AN EMERGENCY
1) NAME________________________________________ RELATIONSHIP________________________
DAYTIME PHONE___________________________ CELL PHONE _______________________________
2) NAME________________________________________ RELATIONSHIP________________________
DAYTIME PHONE ___________________________ CELL PHONE _______________________________

**SIGNATURE** ______________________________________ **DATE**___________________________

**(OVER)**

# NATIONAL TRAIL LOCAL SCHOOL DISTRICT
# EMERGENCY MEDICAL AUTHORIZATION

EM/8-93/HB639

SCHOOL BUILDING ____________________________________

STUDENT NAME ________________________________________
Last First Middle

ADDRESS ____________________________________________

____________________________________________________

TELEPHONE __________________________________________

PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:
Mother's name _____________________Daytime Phone____________

Mother's place of employment ________________________________

Father's name ______________________Daytime Phone____________

Father's place of employment _________________________________

Other's name _______________________Daytime Phone____________

Name of Relative or Childcare Provider: ________________________

________________________________Relationship________________

Address ____________________________Phone ________________

PLEASE USE BALLPOINT PEN AND PRESS FIRMLY FOR LEGIBLE COPY.
COMPLETE THIS FORM AND RETURN IT TO THE SCHOOL OFFICE IMEDIATELY

Grade_________ Birthdate ___________________

Sex ________ Bus No. ___________

Teacher (Gr. K-6 only) _____________________________________________

Date Entered (new students only) _____________________________________

Student lives with ____ Father & Mother ____ Mother only ____ Father only

Other (explain)____________________________________________________

**To be certain the school has enough contacts in case of an emergency, please list two additional people:**

Name ______________________ Relationship __________ __Phone______________

Name ______________________ Relationship ____________ Phone ______________

List below the names of all brothers and sisters:

_________________________________________ School _______________________

_________________________________________ School _______________________

_________________________________________ School _______________________

*******************************************************************************************************************

## PART I OR II MUST BE COMPLETED

*PART I – TO GRANT CONSENT*

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _______________________________________________ Phone_________________________________________

Dentist _______________________________________________ Phone_________________________________________

Medical Specialist ______________________________________ Phone_________________________________________

Local Hospital _________________________________________ Emergency Room Phone__________________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-name doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonable accessible. This includes, but is not limited to, prevention, recognition, and assessment of athletic injuries (assessment), the management, treatment, disposition, and reconditioning of acute athletic injuries (treatment), and medical care related to such assessment and treatment.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Signature of Parent/Guardian: __________________________________________________Date:________________________

Address:______________________________________________________________________________________

*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 action:

______________________________________________________________________________________________

Signature of Parent/Guardian:_________________________________________________Date:________________________

Address: ______________________________________________________________________________________

**OVER**

# NATIONAL TRAIL LOCAL SCHOOLS
# STUDENT DIRECTORY INFORMATION NON-RELEASE FORM
# 2017-2018

This form will be kept on file in the office during the current school year.
No information concerning any student will be released to the press, unless permission is given, or used for profit making purposes.

Please place a check mark in the appropriate boxes and sign below. **All sections must be completed.**

Occasionally the school office receives requests for directory information for a variety of reasons such as PTA functions, group meetings, after school programs, etc.

Section 3319.321 of the Ohio Revised Code addresses directory information that can be made available as follows:

Student's name, address, telephone listing, date and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, date of attendance, date of graduation and awards received.

☐ YES, this information May be made available. ☐ NO, this information may not be made available.

The schools may use photos and articles to publicize the various activities and accomplishments of our students. Whenever possible, we will use pictures of academic, athletic and other activities.

**My child's picture may be published by the school.**

☐ YES ☐ NO

On occasion the media may cover activities/events that occur at school. Your child's picture may appear in the media following these events.

**My child's picture may appear in the media.**

☐ YES ☐ NO

The schools may videotape your child for educational purposes.

**My child may be videotaped for educational purposes.**

☐ YES ☐ NO

Student's Name ______________________________

Teacher or Grade Level ______________________________

Parent/Guardian Signature ______________________________

Date ______________________________

**National Trail Schools**
**STUDENT HANDBOOK AGREEMENT**
# 2017-2018

(The Student Handbook is found in the front of the Student Planner)

*PLEASE FILL OUT (USE DARK INK) AND SIGN THIS FORM. Student must return it to his/her homeroom teacher or choice teacher by Friday, September 1 2017.*

_______________________________________ __________
Student's full name (printed) Grade

**We have read, understand, and agree to and abide by all sections of the Student Handbook.**

*Including:*
1. General Information
2. Code of Conduct
3. Student Dress Code
4. Attendance Policy
5. Safety Procedures
6. Medical Information
7. Other information

Student Signature_______________________________________

Parent/Guardian 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?

☐ No If YES, please explain.

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

☐ 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 |
|---|---|---|
| | | |

**National Trail Local School District**

**Attention:**

# Kindergarten and Elementary Bus Riders!!!

**(Childcare arrangements)**

## Dear Parents,

If your child will ride the bus to or from a location **other** than your home address, you must fill out an "**alternate pick up and drop off**" form available in the NT Elementary Office. This form needs to be turned into the Transportation Office **prior** to the start of school year or your child will be transported **only** to and from their home address.

# NATIONAL TRAIL
## Bus Transportation Information

# ALTERNATE PICK UP and DROP OFF

Child's Name: ____________________________________________Grade________

(Please Circle)
**YES NO** **Child will ride to and from their home address.**

**YES NO** **Child will NOT ride school bus.**

**YES NO** **Childcare arrangements unknown at this time.**

**ALTERNATIVE BUS PICK-UP AND/OR DROP-OFF LOCATION**

If your child needs to be picked up or dropped off everyday of the school year at a location **other** than your home, please complete the following. The information that you provide here will become your child's regular bus stop for the school year. Any occasional changes to the regularly scheduled stop location will require a **written parent note** for each day of the requested change.

**Morning Pick-Up:**

Address:_______________________________________________________________
Name of Caregiver: _______________________________________________________
Phone Number of Caregiver: ________________________________________________

**Afternoon Drop-Off:**

Address: _________________________________________________________________
Name of Caregiver: _________________________________________________________
Phone Number of Caregiver: ________________________________________________

Parent Name: ____________________________________________
Parent Signature: ___________________________________________
Date:___________________________________________________
Parent Phone Number: ____________________________________

National Trail Schools
6940 Oxford-Gettysburg Road
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NT Parents/Guardians,

We are trying to develop a parent contact list using email. This list would be useful to send out update information and newsletters to parents. If you are interested in using email as a means of communication this year please fill out the items below.

Student name ___________________________________________

Parent name ____________________________________________

Email address ___________________________________________

Thank you,