

**KINDERGARTEN REGISTRATION CHECKLIST**  
**(please return forms in this order)**

Child's Name \_\_\_\_\_

Student Emergency Card (both sides filled out & signed) \_\_\_\_\_

CA-60 Information Data \_\_\_\_\_

Permission Form \_\_\_\_\_

Racial Ethnic Enrollment Form \_\_\_\_\_

Bus Form \_\_\_\_\_

Preschool Questionnaire \_\_\_\_\_

Student Residency Form (Utility Bill and Driver's License) \_\_\_\_\_

Developmental & Social Form \_\_\_\_\_

Concussion Form \_\_\_\_\_

Internet Form \_\_\_\_\_

Personal Use Device Form \_\_\_\_\_

Immunization Release Form \_\_\_\_\_

Birth Certificate \_\_\_\_\_

Immunization Record \_\_\_\_\_

Health Appraisal Form \_\_\_\_\_

Vision Test \_\_\_\_\_

Added to Powerschool \_\_\_\_\_

Byron Elementary School 2024-2025  
**STUDENT REGISTRATION/EMERGENCY DATA INFORMATION**

Student Name \_\_\_\_\_ Teacher \_\_\_\_\_  
Last Name First Name Middle

Telephone Number ( ) Age Grade

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
(Number/Street)

County: ☐ Shiawassee ☐ Genesee ☐ Livingston ☐ Other: \_\_\_\_\_

Mailing Address (if different, such as P. O. Box) \_\_\_\_\_  
(City)

Has your telephone number or address changed since last school year? ☐ Yes ☐ No

Birthplace \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

School last attended \_\_\_\_\_  
Name of School Address City State

**FATHER'S INFORMATION**

Father's Name	Father's Email	Father's Place of Work
Home Telephone # (if different from above)	Cell Telephone #	Work Telephone #
( )	( )	( )

**MOTHER'S INFORMATION**

Mother's Name	Mother's Email	Mother's Place of Work
Home Telephone # (if different from above)	Cell Telephone #	Work Telephone #
( )	( )	( )

With whom does the child reside: ☐ Both Parents OR  
☐ Mother ☐ Father ☐ Other: \_\_\_\_\_

Stepmother's or Stepfather's name (if any): \_\_\_\_\_

Please list name and date of birth of siblings:

Name	Date of Birth	Name	Date of Birth

If your child needs to leave school due to illness/injury and we are unable to contact anyone at home or on the cell phone numbers, do you want to be contacted at work so you can arrange for someone to pick up your child from school? ☐ YES ☐ NO

Please contact one of the following responsible parties who are willing to care for my child in the event of illness/injury if we are not available or cannot be reached.

(Please list at least two people, if possible.)

Name	City	Home Telephone Number	Cell Telephone Number

Please complete health section on back.

Student Name \_\_\_\_\_  
Last Name First Name Middle Initial

Health Conditions (*please check the appropriate box*):

☐ NONE

☐ ASTHMA

☐ *My child carries an inhaler.*

("Authorization for the Possession and Use of Asthma Inhalers or Prescribed Emergency Medication" form *must be completed and signed by a physician each school year.*)

☐ SEIZURES

☐ ALLERGIES

Type:

☐ bees

☐ food: \_\_\_\_\_

☐ seasonal

☐ other: \_\_\_\_\_

☐ *My child carries an EpiPen.*

("Authorization for the Possession and Use of Asthma Inhalers or Prescribed Emergency Medication" form *must be completed and signed by a physician each school year.*)

☐ Please list any other important health conditions:

\_\_\_\_\_  
\_\_\_\_\_

Legal Restrictions: In the case of separated or divorced parents, are there any legal restrictions on the release of the child to either parent? If yes, please explain and provide court documents to the office.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospital of your choice in event that an injury needs immediate attention and no one can be located:

Name of Hospital \_\_\_\_\_

I understand that there is an electronic version of the Byron Elementary Student Handbook on the Byron Area Schools website, as well as a hard copy available in the Byron Elementary Office. I understand the rights and responsibilities pertaining to students regarding the rules, guidelines, procedures and policies for the school district. I also understand that this handbook supersedes all prior handbooks and other written materials on the subjects contained therein.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Byron Area Schools Student Residency Questionnaire

A student may be eligible for additional educational services through Title I Part A, Title I Part-C Migrant, and/or Federal McKinney-Vento Assistance. Eligibility can be determined by completing this questionnaire. ***All information provided on this form is confidential. Complete one form per FAMILY.***

Where are you and your family currently staying? (Check one box)

## SECTION A

☐ • Rent/own our own home.

**STOP:** If you rent/own your own home, sign below and send it back to school.

## SECTION B

- ☐ • Temporarily with another family because we cannot afford or find affordable housing.
- ☐ • With an adult that is not a parent or legal guardian, or alone without an adult.
- ☐ • In a hotel/motel.
- ☐ • In a vehicle of any kind, trailer park or campground without running water/electricity, abandoned building or substandard housing.
- ☐ • In an emergency/transitional shelter.
- ☐ • Awaiting foster care/temporary foster care placement, or currently in first six months of foster care
- ☐ • Unsheltered
- ☐ • Unaccompanied youth: not in the physical custody of a parent or guardian.
- ☐ • Other (specify):

If you checked a box in Section B, your child/children may be eligible for additional educational services through Title I, Part A, Title I Part C-Migrant, or Title X, Part C-Federal McKinney-Vento Assistance Act. Please complete the information requested below.

Student Name	Male/Female	DOB	Grade	School Name

Would you like to be contacted by a member of the school system's Education for Homeless Children and Youth program staff?

- ☐ • Yes
- ☐ • No

The undersigned certifies that the information provided above is accurate.

**Print** Parent/Guardian Name/Adult Caring for Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Phone Number Street Address City Zip \_\_\_\_\_

# Preschool Questionnaire

Child's name \_\_\_\_\_

Has your child attended preschool? \_\_\_\_\_yes \_\_\_\_\_no

If yes, please check what kind of program, delivery method and schedule.

## **Program**

- \_\_\_\_\_ Great Start Readiness Program (GSRP)
- \_\_\_\_\_ Head Start
- \_\_\_\_\_ Early Childhood Special Education Classroom
- \_\_\_\_\_ Young 5's /Developmental Kindergarten
- \_\_\_\_\_ Child Care – Home Based
- \_\_\_\_\_ Child Care Center
- \_\_\_\_\_ Family/Relative Care
- \_\_\_\_\_ Tuition Based Preschool

## **Delivery method**

- \_\_\_\_\_ School
- \_\_\_\_\_ Community Based
- \_\_\_\_\_ Home Based

## **Delivery Schedule**

- \_\_\_\_\_ Part Day 4 Days Per Week
- \_\_\_\_\_ Part Days 5 Days Per Week
- \_\_\_\_\_ School Day 4 Days Per Week
- \_\_\_\_\_ School Day 5 Days Per Week
- \_\_\_\_\_ Served by Family Child Care Center

# **Byron Area Schools Personal Device**

## **Student User Agreement**

### **Purpose:**

Students possess devices that allow them access to information and resources easily; the opportunities these devices offer students are limitless, borderless, and instantaneous. In an effort to allow students increased learning opportunities and to take control of their learning, Byron Area Schools will allow students to use some personal digital learning devices in school for educational purposes. Connecting to the Byron Area Schools' wireless network with personal devices is a privilege, not a right. Students who desire to participate **must** follow the responsibilities stated in Byron's Network Access Agreement as well as the following guidelines:

### **Device Types:**

For the purpose of this policy, the word "device" means a privately owned wireless portable electronic piece of equipment including but not limited to laptops, netbooks, tablet computers, iPod touches, and smart phones.

### **Guidelines:**

1. Any student who wishes to use an electronic device within Byron Area Schools must read and sign this agreement and submit it to their school building as directed. Failure to read and sign this agreement will disqualify a student to use a personally owned electronic device in school buildings during school hours.
2. Special exceptions to this policy will be made for those students who have specific provisions in their IEPs.
3. Students must comply with all district staff requests to shut down the device or close the screen or otherwise cease using the device during school hours in school buildings.
4. The student takes full responsibility for the device and keeps it at all times. The school is not responsible for the security of the device including theft, loss, or damage. The District will not reimburse students for devices that are stolen, lost, or damaged.
5. The student is responsible for the device's proper care, including any costs of repair, replacement or any modifications needed to use the device at school. The District will not allocate funds or provide technology support resources to repair, replace, modify, or otherwise maintain usability of personally owned devices.
6. The District reserves the right for staff to inspect a student's personal device if a staff member has a reasonable suspicion that the student has violated Board policies, administrative procedures, school rules or codes of conduct, or has engaged in other misconduct or potential criminal activity while using his/her personal device. Students must not disable the device (lock it, remove battery, etc.) if the District has reasonable suspicion as outlined above.
7. Violations of any Board policies, administrative procedures or school rules involving a student's personally owned device may result in the loss of privilege to use the device in school and/or disciplinary action.
8. Students must present staff members with a pass if they are using a device in areas outside of the classroom (hallway, gym, library, etc...) for class related purposes.
9. Recording still or video images is prohibited unless specifically authorized by a staff member. All such recording shall take place under supervision of the authorizing staff member or another staff member designated by the authorizing staff member.
10. Posting or transmitting recorded images or video shall be limited to that which is related to school assignments and projects and shall only be done in accordance with the District policy.
11. The use of social media such as Facebook, Twitter, Instagram, Snapchat, Cyberdust, etc. while on school premises are only permitted with explicit permission from a staff member for educational purposes only. Other uses of social media will result in serious consequences, including the loss of using devices.
12. Cyberbullying on school premises with allowed devices will result in the loss of device privileges in addition to other possible disciplinary measures.
13. Zones: There will be designated areas (clearly visible) detailing how devices may be used. Descriptions of those areas follow:
  - RED: No use of any device.
  - YELLOW: With staff discretion.
  - GREEN: Students may use device following district guidelines.

# **Byron Area Schools Personal Device**

## **Student User Agreement**

### **Cybersafety**

Byron Area Schools uses a web filter to block inappropriate content from reaching student devices. However, despite every effort for supervision and filtering, all users and students' parents/guardians are advised that access to the network may include the potential for access to content inappropriate for school-aged students. Every user must take responsibility for his or her use of the network and make every effort to avoid those types of content. Every user must report security or network problems to a teacher, administrator, or system administrator. Parents/guardians please be advised that if your child accesses the network supplied by your cellular provider, the school will not be able to filter any content over those networks.

### **Personal Safety**

In using the network and Internet, users should not reveal personal information such as home address or telephone number.

### **Confidentiality of User Information**

Personal identifiable information concerning students may not be disclosed or used in any way on the Internet without the permission of a parent or guardian. Users should never give out private or confidential information about themselves or others on the Internet.

### **Student Use of Interactive Web 2.0 Tools**

Online communication is critical to the students' learning of 21st Century skills, and tools such as blogging, podcasting, and chatting offer an authentic, real-world vehicle for student expression. With the use of Google Documents, Moodle, classroom blogs, e-mail, podcast projects, chat, or other Web interactive tools, students should follow all established Internet safety guidelines including:

- The use of Google Docs, Moodle, blogs, podcasts or other web 2.0 tools is considered an extension of the classroom. Therefore, any speech that is considered unacceptable in the classroom is also unacceptable in all uses of blogs, podcasts, or other web 2.0 tools. This includes—but is not limited to—profanity, racist, sexist, or discriminatory remarks.
- Students using Google Docs, Moodle, blogs, podcasts or other web tools are expected to act safely by keeping ALL personal information out of their posts.
- Students should NEVER post personal information on the web without permission from a parent or legal guardian (including, but not limited to, last names, personal details such as address or phone numbers, or photographs).
- Students should NEVER, under any circumstances, agree to meet someone they have met over the Internet.
- Students should never link to web sites from their blog or blog comments without reading the entire article to make sure it is appropriate for a school setting.
- Students using such tools agree to not share their username or password with anyone besides their teachers and parents and treat Web posting spaces as classroom spaces.

### **Personal Device User Agreement Violations and Consequences**

It is one of the technology goals of the District to ensure that each user's interactions with technology contribute positively to the learning environment both at school and in the community. Byron Area Schools supports the positive use of technology for the purpose of enhancing and supporting learning at any time of the day. It is therefore expected that users of personal devices will comply with Byron Area Schools policies, act in a responsible manner, and will honor the terms and conditions set by the classroom teacher, and the school staff. Failure to comply with such terms and conditions may result in temporary or permanent loss of access as well as other disciplinary or legal action as necessary, up to and including expulsion. When a student does not follow established guidelines, the device will be confiscated, and a parent will have to pick up the device from the office. The wireless access provided to the devices is designed to enhance students' educational experience and increase authentic students' engagement. Connecting to the Byron Area Schools' wireless network with personal devices is a privilege, not a right.

## **Byron Area Schools Personal Device Student User Agreement**

### **Student Section**

I have read, understand and will abide by the Personal Device agreement. I further understand that violations of the regulations may constitute a criminal offense and will be reported to the proper authorities and/or agencies. Should I violate any of the terms of this agreement, my access and privileges may be revoked, and school disciplinary and/or appropriate legal action may be taken.

Student Signature\_\_\_\_\_

Date\_\_\_\_\_

### **Parent Section**

As a parent or guardian of the above-named student, I have read and understand the Personal Device agreement. I hereby give permission for my student to use their own personal device under the discretion of teachers during class activities.

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

Date\_\_\_\_\_



# PERMISSION SLIP FOR BYRON AREA SCHOOLS

Student Name	Nickname	Date of Birth
Street Address	City	State, Zip Code
Place of Birth		

## Permission for Trips

☐ Yes ☐ No

Initialed\_\_\_\_\_

During your child's stay at Byron Elementary, there will be an occasional field trip. Rather than send home a permission slips each time, this will be the only one that needs to be signed. However, notes will be sent home at least one week prior to any trip informing you of the time, date and destination of all field trips. Safety to, from and during the trip will be a priority.

## Permission for Use of Photos

☐ Yes ☐ No

Initialed\_\_\_\_\_

Byron Area Schools occasionally photographs special events/happenings throughout the district or videotapes student activities in the classroom. The pictures may be placed on bulletin boards, appear in building or district publications and our elementary yearbook. In addition, pictures or names may appear in local newspapers and on the district website/Facebook

## Permission for Medical Aid Topical

☐ Yes ☐ No

Initialed\_\_\_\_\_

This allows our nurse/office staff to apply antibiotic ointment and anti-septic wipes for cuts along with bandages, anti-itch spray for itchy rashes, and Vaseline to chapped lips as needed. If you would like to send in Tylenol/Motrin, cough drops or any other prescription/nonprescription, please fill out a form in the office.

I have read and understand this permission slip. I may change or revoke any aspect of this agreement at any time by submitting a new form.

Parent Signature\_\_\_\_\_

Date\_\_\_\_\_

# Byron Area Schools

## NETWORK ACCESS AGREEMENT FOR STUDENTS

Please read this document carefully before signing. The signatures at the end of this document are legally binding and indicate that the signing parties have read all of the terms and conditions carefully and understand their significance.

*Your child's name (hereinafter referred to as "Student"), Byron Area Schools (hereinafter referred to as "District") and Internet, local network, electronic mail, and electronic bulletin board (hereinafter referred to as "Network").*

**In exchange for the privilege of using the Network resources (for education purposes only) at school, I understand and agree to the following:**

- A. The use of the Network is a privilege that may be revoked by the District at any time for inappropriate use.
- B. The Student, his or her parents or guardians, and the District acknowledge that it is impossible for the District to restrict access to all controversial material on the Network. The District reserves the right to review any material stored in files or storage devices believed to be unlawful, indecent, obscene, pornographic, abusive, or otherwise objectionable.
- C. Any loss of security of an account or password should be reported immediately to any appropriate Network administrator.
- D. The District and/or Network does not warrant that the functions of the system will meet any specific requirements the user may have, or that it will be error free or uninterrupted. Neither the District nor the Network will be liable for any direct or indirect damages (including lost data, information, or time) incurred in connection with the use of the Network. Use of any information obtained via the Network is at your own risk.
- E. There are many other uses, both appropriate and inappropriate, that do not appear here, and you are required to ask if you have any questions about whether an activity is permitted.

Examples of Appropriate Use	Examples of Inappropriate Use
Using educational games or simulations specifically assigned by a teacher	Engaging in activities not approved or assigned by the teacher.
Searching for information and using it to form your own digital work	Plagiarism in any form.
Using school software to complete teacher directed work.	Using school software for personal use.
Using e-mail under the direction and supervision of a teacher for a school project.	Reading and/or writing personal e-mails, chatting online, instant messaging, and use of non-school email accounts.
Log in using your username and password only	Impersonating another user on the Network (using someone else's username and password)

**F. Consequences for Misuse of the Network:**

- 1. First Offense – Student is sent directly to an administrator and his/her parents are contacted. The student loses Network privileges for 10 days.
- 2. Second Offense – Student is sent directly to an administrator and his/her parents are contacted. The student loses Network privileges for the remainder of the academic school year and/or length of time specified by the school administrator.
- 3. Vandalism – Student is sent directly to an administrator and his/her parents are contacted. Malicious destruction of hardware or software will result in immediate and long-term removal from the Network. Disciplinary and/or legal action will follow depending on the severity of the offense. Users may be required to make full financial restitution for any unauthorized expenses or damages incurred to the Network.

**As an Internet/Network User at Byron Area Schools:**

1. I will not use the Byron Area Schools Network to violate any laws or rules in the student handbook.
2. I will not reveal any personal information (name, address, or telephone number) about me or about anyone else, without permission of my teacher.
3. I will not use anyone else's username and password.
4. I will not share my username and password with anyone else. I understand that if I share my password and someone else uses it, even without my permission, I will be held responsible for their actions as if they were my own.
5. I will not use the Network in such a way that it would disrupt the use of the Network by others.
6. I will not harm or destroy any hardware, software or data that belongs to the Byron Area Schools.
7. I will not add or download any hardware or software to Network property belonging to Byron Area Schools.
8. I will not violate any copyright laws or violate any state or Federal law related to copyrighted material or copyrighted software.

***In consideration for the privilege for using the Network, I hereby release the District and/or Network and their employees, and agents and operators from any and all claims of any nature arising from my use, or inability to use the District and/or Network resources. I agree to abide by the rules and regulations of Network usage as set forth herein and as may be added from time to time by the District and/or Network. I agree to abide by the rules and regulations of Network usage as set forth herein and as may be added from time to time by the District and/or Network. These rules will be available in hardcopy form in the Principal's office.***

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Student

\_\_\_\_\_  
Grade

***As the Student's parent or legal guardian, I understand that access to the Network is a privilege provided for educational purposes. I understand that it is impossible for the District to restrict access to all controversial material. I hereby release the District and/or Network and their employees, agents and operators from any and all claims of any nature arising from the use of, misuse of, or inability to use, the District or Network resources. In addition, I agree to pay in full for any fees, expenses, or damages incurred as a result of my child's use or misuse of the Network or Network equipment.***

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

*Before any student may enhance his/her school career through participation in the school's computer network, he/she and his/her parents/guardians must sign the Network Access Agreement, which defines the conditions under which the student may participate. **This agreement will remain in effect throughout the student's school years at Byron (unless revoked, in writing, by his/her parent/guardian).** Failure to abide by all of the terms of the agreement may lead to termination of the student's access to district computers and disciplinary action up to and including suspension from school or referral to law enforcement authorities. Users of the network understand and agree to the following:*

# HEALTH APPRAISAL

**Dear Parent or Guardian:** The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

## PERSONAL

CHILD'S NAME (Last, First, Middle)		DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI / /
PARENT/GUARDIAN (Last, First, Middle)		HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI / /
		WORK TELEPHONE NUMBER ( )

## SECTION I - HEALTH HISTORY

Yes	No	Resolved	#	Is your child having any of the problems listed below?	<b>Birth History:</b>  Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:      If yes, list medications:    Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Examiner's Initials:</b> _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	Allergies or Reactions (for example, food, medication or other)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3	Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4	Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5	Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7	Frequent Colds, Sore Throats, Earaches (4 or more per year)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8	Trouble with Passing Urine or Bowel Movements	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9	Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10	Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11	Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12	Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____		
<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?			
Reason for Medication					
_____/_____/_____ <b>Parent/Guardian Signature</b>			_____/_____/_____ <b>Date</b>		

## SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

### Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: ____/____/____	Visual Acuity Muscle Imbalance Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT Other: _____	Height Weight Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: ____/____/____	Audiometer Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	 Reading: _____ Type: _____ Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> ____ mm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: ____/____/____	Sugar Albumin Microscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: ____/____/____	Level ____ ug/dl	<b>NOTE:</b> Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.									

### Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: ____/____/____

<b>SECTION III - IMMUNIZATIONS</b> <small>Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*</small>			
VACCINES (Circle Type)	DATE ADMINISTERED <small>MM/DD/YYYY</small>		
Hepatitis B (HepB)	1	3	
	2		
DTaP/DTP/DT/Td	1	4	
	2	5	
	3	6	
Tdap	1		
Haemophilus Influenzae type b (HIB)	1	3	
	2	4	
Polio (IPV/OPV)	1	3	
	2	4	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	
	2	4	
Rotavirus (RV1/RV5)	1	3	
	2		
Measles, Mumps, Rubella (MMR)	1	2	
Varicella (Chickenpox)	1	2	
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____			
I certify that the immunization dates are true to the best of my knowledge			
_____ <b>Health Professional's Signature</b>		_____ <b>Title</b>	_____ <b>Date</b>

		<b>SECTION IV - RECOMMENDATIONS</b> <small>(Required for Child Care and Head Start/Early Head Start)</small>
No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
		_____
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness?
		If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other
		_____
Other Recommendations		
_____		
_____		

<b>SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)</b>
I have examined _____ child's name _____'s teeth. As a result of this examination, my recommendation for treatment is: _____ _____
_____ <b>Dentist's Signature</b>
_____ <b>Date</b>

<b>PHYSICIAN'S SIGNATURE</b>			
_____ <b>Examiner's Signature</b>	_____ <b>Date</b>	_____ <b>Examiner's Name (Print or Type)</b>	_____ <b>Degree or License</b>
_____ <b>Number &amp; Street</b>	_____ <b>City</b>	MI _____ <b>ZIP Code</b>	(_____) _____ <b>Telephone</b>

Information required for:

**Early On** - Hearing and Vision Status; Diagnosis; Health Status

**Child Care Licensing** - Physical Exam, Restrictions, Immunizations

**Head Start/Early Head Start** - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

\*\*\*\*\*

Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

## Fall Membership Count Racial-Ethnic Self Identification

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

Gender:        Male \_\_\_\_\_        Female \_\_\_\_\_

This is a two-part question mandated by the state. The first part asks about ethnicity and the second part asks about race. Both part A and B **MUST** be completed. We encourage you to select an answer for **both parts**. If either part (A or B) is not answered, the U.S. Department of Education **requires** the school district to supply an answer on your behalf.

Part A.        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 America or other Spanish culture or origin, regardless of race)

Part B.        What is the student's race? (*Choose one or more*) **If putting more than one, please number them in order of your presence.**

\_\_\_\_\_ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America.)

\_\_\_\_\_ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.)

\_\_\_\_\_ **Black or African American** (A person having origins in any of the black racial groups of Africa.)

\_\_\_\_\_ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

\_\_\_\_\_ **White** (A person having origins in any of the original peoples of Europe, the Middle East or North Africa.)

Parents Signature \_\_\_\_\_ Date \_\_\_\_\_

## BYRON ELEMENTARY SCHOOL DEVELOPMENTAL AND SOCIAL HISTORY

Child's Name \_\_\_\_\_

1. Does your child enjoy books? \_\_\_\_\_ Do you read to your child? \_\_\_\_\_

How often? \_\_\_\_\_

2. Is your child able to remember songs or rhymes? \_\_\_\_\_

3. Does your child recognize shapes (circle, triangle, square, rectangle)? \_\_\_\_\_

4. Can your child recognize some letters of the alphabet? \_\_\_\_\_

5. Is your child able to sit still and listen to a story for 5-10 minutes? \_\_\_\_\_

6. Does your child listen without interrupting while someone else talks? \_\_\_\_\_

7. Is your child able to share and take turns? \_\_\_\_\_

8. Does your child know his/her address? \_\_\_\_\_ Phone number? \_\_\_\_\_

9. Does your child write his/her name? \_\_\_\_\_

10. Has your child had experience cutting with scissors? \_\_\_\_\_

11. Does your child know the names of four or more colors? \_\_\_\_\_

12. Does your child recognize some numbers? \_\_\_\_\_

13. How high can your child count (without missing numbers)? \_\_\_\_\_

14. Can your child take care of his/her own bathroom needs? \_\_\_\_\_

15. How do you discipline your child? \_\_\_\_\_

16. Does your child have any health problems in which the school should be aware?  
\_\_\_\_\_

17. Does our child have any food allergies? \_\_\_\_\_

18. Is your child right or left-handed? \_\_\_\_\_

19. Does our child dress him/herself? \_\_\_\_\_

20. Please check the things your child can do: Button \_\_\_\_\_ Tie Shoes \_\_\_\_\_  
Snap \_\_\_\_\_ Zip \_\_\_\_\_ Lace shoes \_\_\_\_\_

21. What do you expect your child to acquire through the kindergarten?  
experience? \_\_\_\_\_

22. What else would you like your child's teacher to know? \_\_\_\_\_  
\_\_\_\_\_

# REQUIRED CA-60 INFORMATION DATA

Today's date \_\_\_\_\_

Child's full name \_\_\_\_\_ Nickname \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Entry date \_\_\_\_\_ Grade \_\_\_\_\_

Place of birth \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

School last attended \_\_\_\_\_ in City, State \_\_\_\_\_

## FAMILY DATA:

Number of children in family _____	Dates of their birth:		
Names of other children in family:	<u>Month</u>	<u>Day</u>	<u>Year</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

	MOTHER	FATHER
Full name		
Home address		
Home telephone		
Occupation		
Place of employment		
Employer's telephone		
State or country of birth		
Highest educational level attained (9 <sup>th</sup> grade, high school, 2 year college, 4 year college, etc.)		

Language spoken in home _____
With whom does the child live? _____
Step parent (if any) _____
Guardian (if any) _____



Route # \_\_\_\_\_  
Pick-up \_\_\_\_\_  
Drop-off \_\_\_\_\_  
Driver Notified \_\_\_\_\_

# BYRON AREA SCHOOLS

## Bus Registration



Student's Last Name: \_\_\_\_\_ Student's First Name: \_\_\_\_\_

Student's Grade: \_\_\_\_\_ Student's Gender: \_\_\_\_\_

Student's Street Number and Name: \_\_\_\_\_

Student's City: \_\_\_\_\_

\*\*\*Check here **ONLY** if your child **WILL NOT** need school transportation.

☐

Which side of the street is the student's house on? \_\_\_\_\_

Parent's names: \_\_\_\_\_

Emergency phone number: \_\_\_\_\_

Please list names of any siblings enrolled in Byron Schools:

\_\_\_\_\_  
\_\_\_\_\_

Will the student be a regular rider? ☐ Yes ☐ No **OR** Will you call only if you need a ride? ☐ Yes ☐ No

Will your students be picked up or dropped off at another location? \_\_\_\_\_

If yes, please complete the following:

☐ Pick up

☐ Drop off

Describe (babysitter, relative, neighbor, etc.): \_\_\_\_\_

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

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

# BYRON AREA SCHOOLS

## Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the students name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

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*I authorize \_\_\_\_\_ Byron Area Schools \_\_\_\_\_ to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.*

Student's Name: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

Signature of Parent/Guardian  
or Eligible Student: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Printed Parent/Guardian Name: \_\_\_\_\_

**PLEASE RETURN THIS EITHER WAY. IF YES, SIGN AND DATE: IF DECLINING, WRITE NO AND RETURN.  
THANK YOU**