

Date: _____ **Gr:** _____ **Gender:** _____ **Student:** _____

Home Rm: _____ AM Bus: _____ PM Bus: _____ Club Bus: _____ Babysitter Bus: _____

DOB _____ Place of birth _____

Home Address _____

Mailing Address _____

Primary Phone (_____) _____

Is student Hispanic/Latino? _____ Race (check any) Am Indian/Alaskan Native Black Asian White Native Hawaiian/Pac Islander

Is student receiving any special services? _____ (High Ability/GT, IEP, testing accommodations, 504 plan, speech, etc)

Parent/Guardian Information _____

Student Primarily Resides With _____

Parent/Guardian Email _____

Student has one or more parent(s)/guardian(s) serving active duty with the US Military? _____

Mother

Name _____

Address (if not same as student's) _____

Primary # (if not same as student's) (_____) _____

Employer/Occupation _____

Work # (_____) _____

Cell # (_____) _____

Father

Name _____

Address (if not same as student's) _____

Primary # (if not same as student's) (_____) _____

Employer/Occupation _____

Work # (_____) _____

Cell # (_____) _____

Stepmother

Name _____

Employer/Occupation _____

Work # (_____) _____

Cell # (_____) _____

Stepfather

Name _____

Employer/Occupation _____

Work # (_____) _____

Cell # (_____) _____

Guardian

Name/Relationship _____

Employer/Occupation _____

Work # (_____) _____

Other phone/type (_____) _____

Guardian

Name/Relationship _____

Employer/Occupation _____

Work # (_____) _____

Other phone/Type (_____) _____

Name and address of previous school: _____

Please list other children in the family

Name	Birth Year	Relationship	Grade

Emergency Contacts

Please list two adults other than parents or guardians.

Name/Relationship	
Phone/Type ()	
Phone/Type ()	
Name/Relationship	
Phone/Type ()	
Phone/Type ()	

Sitter Name/Addr _____ **Ph** () _____

School Messenger

Middlebury Community Schools has an automated phone calling system. We use this tool to call in **cases of emergency**, to notify you of **school closings** or **delays**, or to notify you of any **uncleared absences**. We can also inform you of any **general school announcements**(special events etc).

- Please use this number for the phone calling system () _____.
- I want to receive messages in Spanish when available.
- I do not want to receive any messages from the phone calling system. *By choosing this option you testify that you understand you will receive NO phone calls from the messaging system pertaining to emergencies, closings, delays, absences or school announcements.*

I have read and understand this section of the form _____ **Date:** _____

Non-Prescription Medication Permission

If you wish non-prescription medications to be administered to your child at school, as needed during the school year, please check below and sign to give permission. Prior consent was given for any medications marked with an x. Please make any changes. **We WILL NOT give medications this school year without a signature for this section of the form.**

___ Acetaminophen (Tylenol)	___ Antacid (Tums)	___ Benadryl 25mg
___ Bismuth Tabs (Pepto)	___ Children's Tylenol	___ Ibuprofen 200mg
___ Other (please specify) _____		___ Phenylephrine 10mg (decongestant)

Parent/Guardian Signature: _____ **Date:** _____

Student: _____ **Gr:** _____ **DOB:** _____

MEDICAL CONDITIONS

__ No Medical Conditions

Doctor Name: _____ Phone: (____) _____

__ Asthma

Physician Treating Asthma: _____ Phone: (____) _____

Asthma Triggers: __Exercise __Respiratory Infections __Change in Temperature __Other _____

List Asthma Medications *(please provide doctor's note if taken at school)*

Medication: _____ Dose: _____ When to use: _____

Medication: _____ Dose: _____ When to use: _____

__ Allergies *(Please provide doctor's note for any medications taken at school)*

Physician Treating Allergies: _____ Phone: (____) _____

Allergy 1: _____ Reaction: _____

EpiPen? __Yes __No

Medication: _____ Dose: _____ When to use: _____

Allergy 2: _____ Reaction: _____

EpiPen? __Yes __No

Medication: _____ Dose: _____ When to use: _____

Allergy 3: _____ Reaction: _____

EpiPen? __Yes __No

Medication: _____ Dose: _____ When to use: _____

__ Seizures

Physician Treating Seizures: _____ Phone: (____) _____

Type of Seizures: _____ Date of last seizure: _____

Is student allowed to participate in Physical Education and other activities? __Yes __No

Explain:

List Seizure Medications *(please provide doctor's note if taken at school)*

Seizure Medication: _____ Dose: _____ When to use: _____

Seizure Medication: _____ Dose: _____ When to use: _____

__ Diabetes

Physician Treating Diabetes: _____ Phone: (____) _____

Type of Diabetes: __Type I __Type II

Will your student's doctor's office provide a care plan for the current/upcoming school year? __Yes __No

List Diabetes Medications *(please provide doctor's note if taken at school)*

Medication: _____ Dose: _____ When to use: _____

Medication: _____ Dose: _____ When to use: _____

__Other Medical Condition

Describe: _____

Physician Treating Condition: _____ Phone (____) _____

Will your student's doctor's office provide a care plan for the current/upcoming school year? __Yes __No

List Medications (*please provide doctor's note if taken at school*)

Medication: _____ Dose: _____ When to use: _____

Medication: _____ Dose: _____ When to use: _____

Other Medical History

Has your student had the Chicken Pox disease? If so, date: _____

Please list any broken bones and the date they were

broken: _____

Type and date of any surgery: _____

Note to all Parents/Guardians

If any of the above information changes during the school year, please notify the school nurse.

If your child received any immunizations over the summer, turn in updated records to the school office.

Please review the school medication policy before sending any medication to school with your child.

I have read the above information and I give permission for the necessary school employees to be notified of my child's medical condition(s).

Parent/Guardian Signature: _____ **Date:** _____

Middlebury Community Schools Middlebury, IN

Home Language Survey (HLS)

The Civil Rights Act of 1964, Title VI, Language Minority Compliance Procedures, requires school districts to determine the language(s) spoken by each student in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students as outlined Plyler v. Doe, 457 U.S. 202 (1982).

Please note that the questions below will be given to all students and answers should be student-specific. If a language other than English is spoken by your student, he or she will be given a test to determine their level of English proficiency. The test results will determine if your student qualifies for any additional services to help them become English proficient.

Please answer the following questions regarding the language spoken by your student

1. What language did your **student** first learn to speak? _____
2. What language(s) is spoken most often by your **student**? _____
3. What language(s) is spoken by your **student** at home? _____
4. Was your student born in the US? _____ If NO, date of entry? _____ Student's age _____

Student Name: _____ **Grade:** _____

Parent/Guardian Signature: _____ **Date:** _____

By signing here, you certify that the responses above are specific to your student. You understand that if a language other than English has been identified, your student will be given a test to determine if they qualify for English language development services to help them become fluent in English. Students who qualify for services will also be given an annual assessment to monitor their language proficiency.

El Decreto de los Derechos Civiles de 1964, Titulo VI, Cumplimiento de Normas para Minorías en Lenguaje, requiere a los distritos escolares que determinen el idioma o idiomas que habla cada estudiante. Esta información es esencial para que las escuelas puedan ofrecer instrucción útil a todos los estudiantes de acuerdo con Plyler v. Doe, 457 U.S. 202 (1982).

Por favor tenga en cuenta que esta encuesta se les dará a todos los estudiantes. Las respuestas a la encuesta corresponden solamente a su hijo/a. Si en alguna de las tres preguntas escritas abajo, usted identifica un idioma diferente al inglés, la escuela administrará la Prueba del Desarrollo del Inglés para determinar si su hijo/a calificará para el programa de desarrollo del idioma inglés.

Por favor responda las siguientes preguntas acerca del idioma(s) hablado por su estudiante

1. ¿Cuál es el idioma o el dialecto nativo de su **hijo/hija**? _____
2. ¿Cuál es el idioma(s) más hablado por su **hijo/hija**? _____
3. ¿Cuál idioma(s) habla su **hijo/hija** en casa? _____
4. ¿Nació el estudiante en los Estados Unidos? _____
¿Si NO, cuándo entro el niño/a a los Estados Unidos? _____ ¿Cuántos años tenía? _____

Nombre del Estudiante: _____ **Grado:** _____

Firma del Padre o Guardián: _____ **Fecha:** _____

Al firmar aquí, usted certifica que las respuestas a las tres preguntas mencionadas arriba corresponden a su hijo/a. Usted entiende que si se ha identificado un idioma diferente al inglés, su hijo/a tendrá un examen para determinar si él o ella califica para el programa de desarrollo del idioma inglés, para ayudarlo/a a que sea fluente en inglés. Si entra en el programa de desarrollo del idioma inglés, su hijo/a, tendrá derecho a servicios que lo ayudarán a aprender el idioma inglés y tendrá un examen cada año para determinar su nivel de inglés.

OFFICE USE ONLY/Para Uso de la Oficina Escolar Únicamente

___ Original HLS (student new to IN or first time enrollee) ___ Unable to locate original HLS from previous IN school

Notes: _____

(C.H.I.R.P)

Middlebury Community Schools

I, _____, give Middlebury Community Schools permission to
(parent/guardian)
release the following information concerning my child _____ to the
(name of child)

Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

Child's name, date of birth and immunization information.

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due to according to recommend immunization schedules.

I understand that my child's information will be available to the immunization data registry of another state, a healthcare provider, a local health department, an elementary or secondary school that is attended by the individual, a child care center, and the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, I also understand that other entities may be added to this list though amendment to I.C. 16-38-5-3.

I hereby _____ to the release of such information.

(signature)

(date)

(printed name of Parent or Guardian)

Address

(_____)_____
Telephone Number

Child's Name

Grade Level

Orchard View Elementary School
School

Administration Center: 56853 Northridge Drive, Middlebury, Indiana 46540
Phone: (574) 825-9425 Fax: (574) 825-9426 Web: www.mcsin-k12.org

MIDDLEBURY COMMUNITY SCHOOLS'
COMPUTER NETWORK/INTERNET ACCEPTABLE USE
AGREEMENT

Student Name (Print) _____ School _____ Grade _____

Required grade 6 and above

I have read or had read to me the Middlebury Community Schools' Computer Network/Internet Acceptable Use Agreement. I will follow the guidelines. If I do not follow these guidelines, I understand I will lose my computer network/Internet privileges.

Student Signature: _____ Date: _____



PARENT OR GUARDIAN

As the parent or legal guardian of the student named above, I have read and accept the [Middlebury Community Schools' Computer Network/Internet Acceptable Use Agreement](#). I understand this agreement will be kept on file at the school.

I give permission for my child to have access.

I DO NOT give permission for my child to have access. I am requesting that my child be provided with alternative resources and/or activities.

Parent/Guardian Signature: _____ Date: _____

(Questions should be directed to the School Principal or designee)

OVE Electronic Newsletter

To save on the cost of paper, Orchard View Elementary sends out a Monthly Newsletter and classroom newsletters electronically as much as possible. If you have an e-mail account we encourage you to receive our newsletters electronically. Please provide us with an email below so that we may create parent e-mail lists. Check which option best works for you and return the form to school for each of your students.

The Monthly Newsletter is also available on the school website www.mcsin-k12.org/ove/

*****This form MUST be returned for each student! Please fill out ALL of the information below and check the appropriate box*****

CURRENT E-MAIL ADDRESS



(Please print clearly)

I would like to have the Newsletters **sent to the E-Mail** address provided above. I will be responsible for notifying the school of any changes to my existing E-mail address.

I would like to continue to receive a hard copy of the Newsletters by having them **sent home with my child.**

Date: _____

Parent Name _____

Student Name _____ Teacher _____

ORCHARD VIEW ELEMENTARY SCHOOL

WALKING FIELD TRIP

PERMISSION SLIP

Orchard View Elementary classes will go on walking field trips at different times throughout the school year. The classroom teachers will be in charge of these trips. By signing this permission slip you are giving your child permission to participate in **ALL walking field trips for the current school year.** Classroom Teachers will still notify you when the trip will occur.

Teacher: _____

Name of Student: _____

Date: _____



Parent or Guardian Signature