Oxford City Schools Check Out Authorization Form

Please Note: *<u>ONLY the Parent/Legal Guardian may complete this form</u>.

*Check outs will be allowed ONLY if all requested information is provided and the designated individual appears in the main office with Driver's License/Picture ID.

I (We) _____ the parent(s) of _____
(Parent/Legal Guardian) (Student Name)

Hereby authorize that our child may be checked out of school IN PERSON by the individuals listed below.

Parent address: _____

Parent E-Mail Address: _____

Signed _____ Date _____
(Parent/Legal Guardian Signature)

Parent/Guardian please include your information in the chart below too please.

Name of Person Authorized to Out	√	Relationship To Student	Phone Number	Work Phone Number	Driver's License #

Violations of this policy will terminate a student's checking out privileges by anyone other than a parent/legal guardian in person in the main office.

Parent/Legal Guardian: Please list any legal alerts (Legal documentation must be on file with OMS!) that Oxford Middle School needs to be aware of in regards to your student checking out.

ALERT: _____

_____

_____

_____

Oxford City Schools

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NOTICE OF RECEIPT

_____, a student enrolled in
(Please Print) – Name of Student

_____ School
Name of School

and _____
Name(s) of Parent(s)/Legal Guardian(s)/ Custodian(s)

Hereby acknowledge by our signatures that we have received and read (or had read to us) the local school system's discipline plan including:

1. **Code of Student Conduct (including Internet Acceptable Use and Responsible Use of Technology Policy)**
2. **School Student Handbook**

We understand that these policies apply to all students and parents/legal guardians/custodians in the public schools; to school campuses, school buses, or other school-owned/operated vehicles; and school-related activities and events.

_____
Student's Signature **Date**

_____
Parent's/Legal Guardian's/Custodian's Signature **Date**

_____
Parent's/Legal Guardian's/Custodian's Signature **Date**

NOTES:

1. The student is to sign the above statement. If the student lives with both parents, has two legal guardians or two custodians, both are to sign the statement. If the student lives with only one parent, guardian or custodian, only one signature is required.
2. A separate statement is to be signed for each student.

Oxford City Schools

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I am the parent/legal guardian of the child named below, who is under the age of 18. I hereby provide permission to Oxford City School System (OCS) to include certain personal information (**excluding address, phone, and social security number**) about my son/daughter in publications produced by the Oxford City School System.

I grant permission to the Oxford City Schools to use photographs of my son/daughter, without limitation, for the purposes of advertising, promotion, recognition, or publication (with or without my name). I understand these photos may be used in newsletters, programs, brochures, promotional or instructional videos, or posted on the organization's Web site.

I acknowledge that the use of all or any part of the information pertaining to the above will be at the discretion of the Oxford City Schools for use in public display and is in no way intended to harm those parties involved.

I acknowledge that my child may have the use of e-mail through the Oxford City School website and servers. My child's use of this service is at the discretion of the Oxford City Schools and may be withheld at my request. Service may also be withheld due to violation of the Internet Acceptable Use and Responsible Use of Technology Policy or in response to disciplinary problems.

I agree to hold you and any parties harmless against liability, loss, or damage caused by or arising from the use of any and all information regarding my son/daughter and of any utterance made by me, or material furnished by me in connection with my participation therein.

_____ _____
Signature of Student *Print or Type Name of Student*

_____ _____
Signature of Parent/legal guardian *Print or Type Name of Parent*

_____
Street Address

_____ _____ _____
City *State* *Zip*

***I hereby certify that I am over the age of eighteen and I have read, understood and agree to the foregoing.

_____ _____
Signature of Student *Print Name of Student*

Date _____

ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year: _____-_____

To Parent or Guardian:
The purpose of this form is to provide the school nurse with additional information regarding your child's health needs. The school nurse may contact you for further information. The information requested is essential for the school nurse to meet the health needs of your child.

This information will be kept confidential.

PLEASE complete both sides of this form (Return to the School Nurse)

Name of Student (Last, First, Middle)	Birth Date	Sex	School

Address (Street)

Home Telephone Number:	Cell Phone Number:	Additional Phone Number:	Grade	Teacher/Homeroom

Name of Parent/Guardian (Last, First Middle)	Work Phone Number:

Transportation

☐ Bus Rider Bus Number: ☐ Car Rider ☐ Special Needs Bus ☐ After School

Part I – Health Information

Place your child receives health care:

Physician's Name: _____

Address: _____

Phone: _____

☐ Community Health Center
☐ Health Department
☐ Hospital Clinic
☐ No Regular Place
☐ Private Doctor /HMO

Your child's Insurance Information:

☐ ALL KIDS
☐ Medicaid
☐ No Insurance
☐ Other _____
☐ Private Insurance

Place your child receives dental care:

Dentist's Name: _____

Address: _____

Phone: _____

☐ Community Health Center
☐ Health Department
☐ Hospital Clinic
☐ No Regular Place
☐ Private Dentist /HMO

Preferred Hospital: _____

Part II – Medical History Medical Equipment /Procedures Required at School

☐ Catheter ☐ Gastric Tube ☐ Nebulizer *Treatments* ☐ Oxygen Supplement ☐ Tracheostomy

☐ Vagal Nerve Stimulator (VNS) ☐ Ventilator ☐ Wheelchair ☐ Walker

☐ Other *Please explain:*

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure) Please see your school nurse.

Please Complete Back of Form (Signature Required)

ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year: _____-_____

Part III – Medical History

☐ YES ☐ NO	KNOWN HEALTH PROBLEMS If NO, go directly to the bottom of the page and provide parent/guardian signature If YES, and diagnosed by a physician, answer each question below.
☐ YES ☐ NO ☐ YES ☐ NO	Attention Deficit Disorder (ADD) Attention Deficit Hyperactivity Disorder (ADHD) Requires medication ☐ At school ☐ At Home
☐ YES ☐ NO	Allergies: ☐ Food _____ ☐ Hives/rash ☐ Medications ☐ Insects _____ ☐ Breathing difficulty ☐ Epi-pen ☐ Environmental _____ ☐ Medications _____ ☐ Other:
☐ YES ☐ NO	Asthma ☐ Uses an inhaler at school ☐ Uses an inhaler at home
☐ YES ☐ NO	Blood/Bleeding Problems: ☐Hemophilia, ☐Von Willebrand's, ☐Other ☐ Requires medication *Please explain:*
☐ YES ☐ NO	Frequent Nose Bleeds: *Please explain*
☐ YES ☐ NO	Cancer/Leukemia: *Please explain*
☐ YES ☐ NO	Cerebral Palsy: *Please explain*
☐ YES ☐ NO	Cystic Fibrosis: *Please explain*
☐ YES ☐ NO	Dental Problems: *Please explain:*
☐ YES ☐ NO	Diabetes ☐ Type 1 Diabetes ☐ Monitors Blood Sugars at school ☐ Requires insulin at school ☐ Insulin pump ☐ Glucagon order ☐ Type 2 Diabetes ☐ Managed with diet ☐ Oral medication
☐ YES ☐ NO	Emotional/Behavioral/Psychological: *Please explain:*
☐ YES ☐ NO	Gastrointestinal/Stomach Problems: *Please explain:*
☐ YES ☐ NO	Genetic / Rare Disorders: *Please explain:*
☐ YES ☐ NO	Headaches: *Please explain:*
☐ YES ☐ NO	Hearing Problems: ☐ Right Ear ☐ Left Ear ☐ Both ears ☐ Hearing loss ☐ Hearing aid ☐ Tubes ☐ Cochlear Implant
☐ YES ☐ NO	Heart Condition: ☐ Activity restrictions: ☐ Medications taken at home: *Please explain:*
☐ YES ☐ NO	Hypertension (High Blood Pressure): *Please explain:*
☐ YES ☐ NO	Juvenile Arthritis/Bone-Joint Problems: *Please explain:*
☐ YES ☐ NO	Kidney/ Bladder/ Urinary Problems: *Please explain:*
☐ YES ☐ NO	Scoliosis: ☐ No Treatment ☐ Wears Brace ☐ Surgery ☐ Family History
☐ YES ☐ NO	Seizures/Convulsions: Type of seizure: _____ *Medications:* ☐ Diastat ☐ Klonopin ☐ Versed ☐ Medication taken at home ☐ Other _____ *Please explain:*
☐ YES ☐ NO	Sickle Cell: ☐ Anemia ☐ Trait
☐ YES ☐ NO	Shunt: ☐ VP shunt *Please explain:*
☐ YES ☐ NO	Spina Bifida:
☐ YES ☐ NO	Special Diet: *Please explain:*
☐ YES ☐ NO	Vision Problems: ☐ Wears glasses ☐ Wears contacts ☐ Other
☐ YES ☐ NO	Other Medical Conditions: *Please include <u>any</u> medications taken at home only.*

Required Signatures

Signature of parent(s) or guardian: _____ Date: _____

Signature of school nurse: _____ Date: _____