

Oxford Middle School

Schedule & Locker Distribution Information 2018-2019

| 8 th Grade Students | 7 th Grade Students | Make Up 7 th & 8 th Grades |
|--|--|--|
| Thursday, July 26 th 5:00 p.m. @ OMS | Thursday, July 26 th 6:30 p.m. @ OMS | Monday, July 30 th 8:00 a.m.-3:00 p.m. @ OMS |

At this time you will be able to:

- Pay (MACBOOK USAGE AGREEMENT COST = \$50.00 & SCHOOL ADMINISTRATIVE COSTS = \$15.00)
- Turn in Forms (Forms may be printed from website @ <http://oxford.ocsm.schoolinsites.com>)
- Pick Up Schedule, Student Locker Assignments. (School lockers are included in Student Administrative Cost, student is responsible for providing a combination lock from home for PE Lockers.)
- Purchase Yearbook = \$40.00 (Optional)
- Make initial deposit into cafeteria account. Turn in Free/Reduced Lunch Form.
- Sign-up for Blackboard (free app)

Forms To Be Completed

ALL FORMS MUST BE COMPLETELY FILLED OUT AND ALL COSTS PAID IN ORDER FOR THE STUDENT TO PICK UP HIS/HER SCHEDULE AND LOCKERS.

Forms may be printed from our website -<http://oxford.ocsm.schoolinsites.com> and filled out in advance or if you do not have access to the internet, you may pick up a packet from the school office. Forms are as follows:

- OCS Check Out Authorization Form
- Code of Student Conduct (Including Internet Acceptable Use and Responsible Use of Technology Policy & Media Release Form.) Forms must be completed and signed by **BOTH** the student and the parents/legal guardians.
- Student Health Assessment Form. **PLEASE DO NOT send medication with your student at any time! *If your child takes medication routinely during school hours please complete a medication release form (form provided on the school website) and bring with medication to the school nurse (after school starts). You should have received notification from the school nurse if an Updated Immunization (Blue Form) is required.*

EXPRESS LINE @ Registration

Students will need the following to move immediately to the Express Line to pick up their schedule etc:

- All forms (provided on line or at OMS) **COMPLETELY** filled out by the parent/guardian.
- A copy of your Receipt showing ALL costs (totaling \$65.00) have been paid. (KEEP RECEIPT to present when you pick up your laptop @ "Connect Computer Distribution". *Remember – check our website for your scheduled Macbook pick-up day, date and time!)

WE WILL BE ABLE TO ACCEPT DEBIT/CREDIT, CASH AND/OR CHECKS

Important Reminders

*Any remaining **unpaid account balances and proof of residency** (from a previous school year) **MUST** be cleared before students can pick up schedules and lockers. This includes unpaid account balances for fees, lost or damaged computers/computer parts & library books, etc. Updated Proof of Residency is required when you move or if mail is returned to us. Information required to complete Proof of Residency can be found on our website.

*Any schedule change must be submitted in writing and approved by the principal. Any non-essential schedule change, if approved by the principal, will be assessed a \$20.00 administrative cost. This will need to be paid before any non-essential change can be made.

*Check our website over the summer for the dates and times of the CONNECT MacBook distribution schedule.

Oxford City Schools Check Out Authorization Form

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

*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.

Student _____
(Last Name) (First Name)

I (We) _____ the parent(s) of the above named student,
(Parent/Legal Guardian)

here by 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.

| Name of Person Authorized to ✓ Out | Relationship To Student | Phone Number | Work Phone Number | Driver's License # |
|------------------------------------|-------------------------|--------------|-------------------|--------------------|
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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: _____



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NOTICE OF RECEIPT

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

Name of School _____ 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 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.

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.

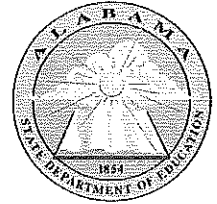
Signature of Student _____ Print or Type Name of Student _____
 Signature of Parent/legal guardian _____ Print or Type Name of Parent _____
 Street Address _____
 City _____ State _____ Zip _____

***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:

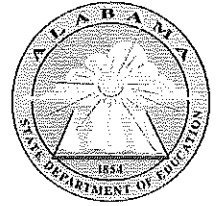
Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure) Please see your school nurse.

Please Complete Back of Form (Signature Required)





ALABAMA STATE DEPARTMENT OF EDUCATION



HEALTH ASSESSMENT RECORD

School Year: _____

Name of Student

Part III – Medical History

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

Required Signatures

(Electronic or Written) Parent(s) or Guardian Signature: _____ Date: _____

(Electronic or Written) School Nurse Signature: _____ Date: _____