

OPS Student Enrollment & Emergency Form

Parents/Guardians: Please complete both sides of the form, sign, date, and return the form to the school's main office. Note that all fields titled, "Primary Phone" and "E-mail" are used when the district automated alert system is activated for school messages.

Student Information:

Student Legal Name: (Last First Middle):		Date of Birth:	
Student Mobile Phone:		Gender:	
Primary Phone:		Grade:	
District of Residence:		Country of Birth:	
Student's Address:			
Mailing Address: (if different)			
Student Resides with:			

Legal Parent/Guardian Information:

	Legal Parent/Guardian	Legal Parent/Guardian
Name: (Last First)		
Relationship to Student:		
Street Address: (if different)		
City, State, Zip:		
Primary Phone: (if different)		
Mobile Phone: (if different)		
Day Phone: (if different)		
Employer: (if applicable)		
E-mail Address:		

Legal Step-Parent/Other Guardian Information:

	Legal Step-Parent/Other Guardian	Legal Step-Parent/Other Guardian
Name: (Last First)		
Relationship to Student:		
Street Address: (if different)		
City, State, Zip:		
Primary Phone: (if different)		
Mobile Phone: (if different)		
Day Phone: (if different)		

► Check all that apply: ☐ Regular Education ☐ Special Education ☐ Speech & Language ☐ 504 Plan

☐ Yes ☐ No My child attended Owosso Public Schools previously. If yes, year? _____ Name of school: _____

☐ Yes ☐ No My child attended a pre-school program prior to entering kindergarten. If yes, name of last school attended (including preschool): _____

☐ Yes ☐ No Has your child been suspended or expelled by the Board of Education of any district?

☐ Yes ☐ No In case of an emergency, I authorize the School to seek medical attention for my child.

Emergency Information: (Other than the Parents/Guardians)

	Emergency Contact #1	Emergency Contact #2	Emergency Contact #3
Name:			
Relationship:			
Day Phone:			

Medical/Special Needs: (Please check and describe any medical condition, medication or disability that would be important for the school to know.)

☐ Asthma ☐ Diabetes ☐ Seizures

☐ Seasonal Allergies - _____

☐ Allergic Reactions (i.e., insect bites, bees, etc) - _____

Provide any other information you feel will assist the school, including health or other conditions: (If more space is needed, please attach information.)

Siblings: (Other children from oldest to youngest)

Name (Last, First)	Birthdate	School / District	Name (Last, First)	Birthdate	School / District
1)			5)		
2)			6)		
3)			7)		
4)			8)		

Race and Ethnicity: (Part A and Part B **MUST** be completed. Please 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**

The above part of the question is about ethnicity, not race. No matter which box you selected above, please continue to answer Part B by marking one or more boxes to indicate what you consider your student's race to be.

Part B: What is the student's race? (choose one or more)

☐ American Indian or Native Alaskan

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

Language: Answer the two questions below. If your response to either question is a language other than English, the school district will give an assessment to see if your student may benefit from English language support.

What language is used most at home? _____

What language is used most by the student? _____

Living Circumstances: Do you currently find yourself in any of the situations below?

☐ In a shelter

☐ Living with friends or other family members due to loss of housing or economic hardship

☐ In a hotel/motel Living in other locations (e.g. in a car, park, bus, train, or campsite)

☐ Foster care placement

☐ Other (please describe): _____

Emergency: In case of an emergency school closing and students are released early, my child has been instructed to:

☐ Drive self

☐ Ride the bus

☐ Wait to be picked up

☐ Walk home

Walk -to Address: _____

Walk-to Name: _____

Walk-to Day Phone: _____

Guardianship:

- In the case of separated or divorced parents, are there any legal restrictions on the release of the child or information to either parent or step-parent?
- If yes, please explain below/ and provide court documentation to the school office.

→ **Signature of Parent or Legal Guardian:** _____ **Date:** _____

It is the policy of the Owosso Public School District that no person shall on the basis of sex, race, color, national origin, or handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination as a student in Owosso schools or any of its programs or activities.



OWOSSO PUBLIC SCHOOLS

Ready for the World

645 Alger Street, Owosso, MI 48867

Phone: 989-723-8131

Kindergarten Waiver Request for 2026-2027 School Year

Student Name: _____

According to Michigan Law, if a child residing in the Owosso Public School district and is not 5 years of age on September 1, 2026 of the school year but will be 5 years of age not later than December 1, 2026 of the school year, the parent or legal guardian of that child may enroll the child in kindergarten for the current school year if the parent or legal guardian notifies the school district in writing that he or she intends to enroll the child in kindergarten. A school district that receives this written notification may make a recommendation to the parent or legal guardian of a child described in this subsection that the child is not ready to enroll in kindergarten due to the child's age or other factors. The parent or legal guardian retains the sole discretion to determine whether or not to enroll the child in kindergarten if the student is 5 years of age not later than December 1, 2026.

Verification of Age (circle one)

Birth Certificate
Court Record

Date of Birth ____/____/____
Government Record
Citizenship Paper

Hospital Record
Other

Parent Name: _____

Evidence of School Readiness Provided by Parent

- 1: _____
2: _____
3: _____
4: _____

Parent Signature _____

Today's Date: _____

Owosso Public School's Recommendation

Administrator: _____ agrees with the recommendation of the parents to enroll in Kindergarten.

Administrator: _____ recommends that _____ begins kindergarten in September of next year for the following reasons:

- 1: _____
2: _____
3: _____
4: _____

Administrator's Signature _____

Today's Date: _____

KINDERGARTEN ENTRY/PRESCHOOL HEARING AND VISION SCREENING RECORD

Michigan Department of Health and Human Services

Health Department/County/Screening Location					
Name			Birthdate		<input type="checkbox"/> Male <input type="checkbox"/> Female
Parent			Phone #		
Address			City, State, Zip		
School Attending				ID#	
Primary Care Provider			Provider Phone #		
Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No			Medicaid #		
<u>Hearing History</u>		Yes	No	<u>Vision History</u>	
Has your child seen a doctor for ear problems?		<input type="checkbox"/>	<input type="checkbox"/>	Has your child been examined by an eye doctor?	
Is your child taking medication for a cold or allergies?		<input type="checkbox"/>	<input type="checkbox"/>	Does your child confuse colors?	
Do you have concerns about your child's hearing?		<input type="checkbox"/>	<input type="checkbox"/>	When your child is ill or tired, do their eyes appear crossed or does one eye wander when looking at an object?	
Does your child have a medically implanted device or use an insulin pump/continuous glucose monitor?		<input type="checkbox"/>	<input type="checkbox"/>		
Do Not Write Below This Line					
HEARING SCREENING			RESULTS		
Preliminary Screening			<input type="checkbox"/> Pass <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Under Care		
			<input type="checkbox"/> Fail <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Retest		
Audiogram			<input type="checkbox"/> Pass <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Under Care		
			<input type="checkbox"/> Fail <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Retest		
VISION SCREENING			RESULTS		
Visual Acuity/2-Line Difference (LEA Symbols)			<input type="checkbox"/> Pass <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye		
			<input type="checkbox"/> Fail <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye		
			<input type="checkbox"/> 2-Line Difference		
			<input type="checkbox"/> 20/50		
			<input type="checkbox"/> FNR/Permanent Difficulty		
			<input type="checkbox"/> Retest		
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail		
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A		
			<input type="checkbox"/> Pass <input type="checkbox"/> Fail		
Parents/Guardians: Please present this certificate of hearing and vision screening when enrolling your child for kindergarten. This is a requirement of the Michigan Public Health Code, Act 368 of 1978 and the Revised School Code of 1976. Retain a copy for your health records.					
<u>Hearing</u>			<u>Vision</u>		
<input type="checkbox"/> Pass			<input type="checkbox"/> Pass		
<input type="checkbox"/> Fail (exam by LHD or physician required)			<input type="checkbox"/> Fail (exam by eye care professional required)		
Child's Name:			Screening Date:		
Health Department:			Technician:		



KINDERGARTEN ORAL HEALTH ASSESSMENT FORM

The Kindergarten Oral Health Assessment law [*Public Health Code Act 368 Section 333.9316*] was passed to ensure that children entering their first year of school are able to receive an oral health assessment (dental screening) prior to starting school. Good oral health is important to help children stay healthy and ready to learn. This optional assessment will let you know if your child has any dental problems that require attention by a dentist. The assessment must be done by a Registered Dental Hygienist, Dentist, or Dental Therapist.

STUDENT INFORMATION

Child's Name (Last, First, Middle)	Date of Birth (mm/dd/yy)
Address (Number, Street, City, Zip Code)	Home/Cell Phone Number
Parent/Guardian Name (Last, First, Middle)	Parent/Guardian Email
School Name	

DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS (Licensed dental professional must complete this section)

Date of Service	Type of service <input type="checkbox"/> Dental Exam <input type="checkbox"/> Dental Assessment	
Findings (check all that apply) <input type="checkbox"/> No urgent needs <input type="checkbox"/> Treated decay <input type="checkbox"/> Untreated decay	Recommendations (check ONE) <input type="checkbox"/> Routine care <input type="checkbox"/> Referral for urgent needs/restorative care or specialist	
Screening Provider (check one) <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Therapist <input type="checkbox"/> Dental Hygienist		
Provider Signature	Agency/Local Health Department	
Provider Name (print)	Phone	

Additional Comments: _____



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 for disease threats to be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information, including the student's 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.

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

I authorize Owosso Public Schools in Owosso, Michigan, to release my child's immunization record to the Michigan Department of Health and Human Services and the 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: _____ Date: _____

Printed Parent/Guardian Name: _____



Owosso Public Schools

Directory Information and Opt Out Form

Student's Name: _____

School: _____ Grade: _____

The Family Educational Rights and Privacy Act (FERPA) requires that Owosso Public Schools obtain your written consent prior to the disclosure of personally identifiable information from your child's education records, unless certain conditions specified by FERPA are met. FERPA distinguishes between personally identifiable information and directory information; however, the District may disclose appropriately designated "directory information" without your written consent, unless you have advised the District to the contrary.

If you do not want your student's directory information released for one or more of the purposes listed below, please complete this form and return it to your student's school office by the first day of school within the given school year.

If you fail to complete and return this form, the District will presume that you give permission to release your student's directory information for all the uses listed below.

Your Opt-Out request will be recorded in the student information system and kept on file in the school's office for 1 school year.

Directory information includes "directory information," as adopted by the Board in Policy 5309 Student Records and Directory Information.

Please check the boxes next to the purpose(s) for which you do not grant the District permission to disclose your student's directory information, below.

Owosso Public Schools may not disclose my student's directory information for the following purposes:

- ☐ For School or District publications, including but not limited to, a yearbook, graduation program, theater playbill, athletic team or band roster, newsletter, and other school and district publications.
- ☐ For School or District auto-dialer system to communicate School or District information.
- ☐ To news media outside the School or District.
- ☐ To the School PTO or District parent organization.

- ☐ To other groups and entities outside of the School or District, including community, advocacy, and/or parent organizations.
- ☐ On official school-related websites or social media accounts.
- ☐ On school employees' personal classroom websites or social media accounts.

Information to U.S. Military Recruiters and Institutions of Higher Education Recruiters

Federal law requires the District to release a secondary school student's name, address, and telephone number to U.S. Military recruiters and institutions of higher education upon their request. If you do not want your student's information released for one or both of those purposes, please check one or both of the boxes below:

- ☐ Do not release my student's name, address, or telephone number to U.S. Military recruiters without my prior written consent.
- ☐ Do not release my student's name, address, or telephone number to institutions of higher education recruiters without my prior written consent.

Field Trips

- ☐ I do not give permission for my student to attend field trips.

Parent/ Legal Guardian Signature: _____

Date: _____ School Year: _____



Tribal Affiliation

Responding to this questionnaire is optional. The information collected will support coordination and communication with Tribal Nations and help the district determine its eligibility to apply for additional funding to support Indigenous learners.

Student Full Legal Name: _____

Parent/Guardian Name(s): _____

Home Address: _____

City: State: Zip Code: _____

Grade: _____ Birth Date: _____

For this data collection, tribal affiliation refers to an individual with ties to one or more Indigenous Nations through citizenship, membership, enrollment, or descendency.

Question A: Is this student tribally affiliated?

- ☐ Yes, the student is tribally affiliated
- ☐ No, the student is not tribally affiliated

Question B: If the student is tribally affiliated, what is their primary tribal affiliation?

(Choose only one)

- ☐ Bay Mills Indian Community
- ☐ Grand Traverse Band of Ottawa and Chippewa Indians
- ☐ Hannahville Indian Community
- ☐ Keweenaw Bay Indian Community
- ☐ Lac Vieux Desert Band of Lake Superior Chippewa Indians of Michigan
- ☐ Little River Band of Ottawa Indians
- ☐ Little Traverse Bay Band of Odawa Indians
- ☐ Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan
- ☐ Nottawaseppi Huron Band of the Potawatomi
- ☐ Pokagon Band of Potawatomi Indians
- ☐ Saginaw Chippewa Indian Tribe of Michigan
- ☐ Sault Ste Marie Tribe of Chippewa Indians
- ☐ Not Listed

UNDERSTANDING CONCUSSION

Some Common Symptoms

Headache	Balance Problems	Sensitive to Noise	Poor Concentration	Not "Feeling Right"
Pressure in the Head	Double Vision	Sluggishness	Memory Problems	Feeling Irritable
Nausea/Vomiting	Blurry Vision	Haziness	Confusion	Slow Reaction Time
Dizziness	Sensitive to Light	Fogginess	"Feeling Down"	Sleep Problems
		Grogginess	Lost Consciousness	

WHAT IS A CONCUSSION?

A **concussion** is a type of **traumatic brain injury** that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

IF YOU SUSPECT A CONCUSSION:

- 1. SEEK MEDICAL ATTENTION RIGHT AWAY – DON'T HIDE IT, REPORT IT.** Playing or practicing with concussion symptoms is dangerous and can lead to a longer recovery. A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Ignoring symptoms and trying to "tough it out" often makes it worse.
- 2. KEEP YOUR STUDENT OUT OF PLAY –** Concussions take time to heal. Don't let the student return to play the day of injury and until a health care professional says it's okay. A student, who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.
- 3. TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION –** Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he must be kept out of athletic activity the day of the injury. The student shall only return to activity (practice, scrimmage or competition) with written unconditional permission from an MD, DO, Physician's Assistant or Nurse Practitioner. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

Owosso Public School

CONCUSSION AWARENESS EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and/or the Concussion Fact Sheet for Students provided by _____

Sponsoring Organization

Participant Name Printed

Parent or Guardian Name Printed

Participant Name Signature

Parent or Guardian Name Signature

Date

Date

Return this signed form to the participant's MHSAA member school. The school should keep this document on file for five years following the student's high school graduation.

Participants and parents please review and keep the educational materials available for future reference.

Student Name _____

Last, First & Middle

STUDENT RESIDENCY QUESTIONNAIRE



The information requested on this form fulfills one requirement of the McKinney-Vento Act 42 U.S.C. 11434a(2), which is also known as the Title X, Part C, of the No Child Left Behind Act. The answers you give will help determine the services your student may be eligible to receive. **No student(s) will be discriminated against based upon any of this confidential information provided.**

School: _____ Grade: _____ Date of Birth: _____ Age: _____

Gender: M or F Ethnicity: _____ Parent/Guardian Name: _____

Phone Number: _____ Current Street Address: _____

Today's Date: _____ City, State, Zip _____

Complete Section A... IF you are living in a TEMPORARY RESIDENCE. If you have a **PERMANENT residence** (such as a house, an apartment, or a condo), you do not need to complete.

Section A.

1. **Is the student living in a temporary place such as:** motel/hotel, car, camper, emergency shelter, friend's house, relative's house? **YES** _____ **NO** _____
2. **Was the student forced into a temporary place due to loss of housing** from eviction, foreclosure, financial hardship, domestic violence, fire or natural disaster, death or incarceration of parent/guardian, or other crisis situation? **YES** _____ **NO** _____

If either question above is answered Yes, please explain further: _____

If you answered **Yes to BOTH QUESTIONS** in **Section A**, please **complete Section B** below.

Section B. Please check the box that best describes where the student is presently living:

- ☐ In the home/apartment of a friend or relative (sharing someone else's home because you have nowhere else to live)
- ☐ In a shelter or transitional housing program (examples: family shelter, domestic violence shelter, youth shelter, etc.)
- ☐ In a hotel or motel because of economic hardship, eviction, foreclosure, fire, lack of deposits for permanent housing, etc.
- ☐ In a tent, car, van, abandoned building, on the streets, at a campground, in the park, or at another unsheltered location
- ☐ Moving from place to place

Check the box that best describes with whom the student resides. (Please note: legal guardianship may be granted only by a court; students living on their own or with friends or relatives who do not have legal guardianship are allowed to enroll in and attend school. The school cannot require proof of guardianship for enrollment or continued attendance.)

☐ Parent(s) ☐ Legal Guardian(s) ☐ Caregiver(s) who are not legal guardian(s) (example: relatives, friends, parent of friends, etc.)

☐ Other, please specify: _____

☐ Is this student awaiting foster care placement? If so, please explain: _____

Please list all student(s) and their age(s) of this family under your care: _____

Section C. I understand that the information provided above is correct, true and current. I also understand that enrolling a child at Owosso Public Schools under false pretense is punishable by law.

Signature of Parent/Guardian or Other Person completing form

Relationship to Student

Date

SCHOOL USE ONLY: _____ Student qualifies _____ Student does not qualify _____ Student coded MV at previous district

Building Liaison _____ Date _____

District Liaison Signature _____ Date _____