



Mio AuSable Schools

1110 W. 8th Street, Mio, MI 48647
www.mio12.net

Elementary Office 989-826-2430
Middle School/High School Office 989-826-2481

Dear Parent/Guardian:

Thank you for choosing Mio AuSable Schools for your child's educational journey. We welcome your partnership to help your child reach his or her potential.

The following documents are required for registration for grades K through 5.

Return this enrollment packet to the school office, along with the following:

- An original birth certificate (the school office will make a copy)
- A documentation of your residency (utility bill, rent receipt, lease agreement)
- Immunization record
- School of Choice application, if applicable
- Custodial Orders or Guardianship papers, if applicable
- Special Education IEP, if applicable

Thank you!

Mio AuSable Elementary School

Mio AuSable Schools

Registration Form

PLEASE PRINT ALL INFORMATION ON BOTH SIDES OF THIS FORM

STUDENT INFORMATION

Date _____

Student's Legal Name (Last, First, Middle)	
Name to be used at school	Student's Grade
Gender: M F	Birthdate
Birthplace (City/State)	
Ethnicity: African American Asian Caucasian Hispanic/Latino Alaskan Native Native Hawaiian <small>Ethnicity information is voluntary, for statistical purposes and will not be used in any other manner.</small>	
Home Language	First Language
Student's Primary Phone	
Student's Residence Address	City Zip
Student's Mailing Address	City Zip
School district you reside in:	Township: Elmer Big Creek Mentor Greenwood
Student Lives With: <small>(please check)</small> <input type="checkbox"/> Both Natural Parents <input type="checkbox"/> Father Only <input type="checkbox"/> Mother Only <input type="checkbox"/> Divorced-Joint Custody <input type="checkbox"/> Father/Stepmother <input type="checkbox"/> Mother/Stepfather <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Court Placed <input type="checkbox"/> Other	

GUARDIAN INFORMATION

Guardian 1 Name	Emergency Contact? Yes No
Relationship to student: <small>(mother, father, etc)</small>	Lives with Student? Yes No
Martial Status: Married Single Separated Divorced Widowed	
Guardian Phone	Guardian Address if different than above
Guardian Work Place	Guardian Work Phone
Guardian Email	

Guardian 2 Name	Emergency Contact? Yes No
Relationship to student: <small>(mother, father, etc)</small>	Lives with Student? Yes No
Martial Status: Married Single Separated Divorced Widowed	
Guardian Phone	Guardian Address if different than above
Guardian Work Place	Guardian Work Phone
Guardian Email	

Guardian 3 Name	Emergency Contact? Yes No
Relationship to student: <small>(mother, father, etc)</small>	Lives with Student? Yes No
Martial Status: Married Single Separated Divorced Widowed	
Guardian Phone	Guardian Address if different than above
Guardian Work Place	Guardian Work Phone
Guardian Email	

Guardian 4 Name	Emergency Contact? Yes No
Relationship to student: <small>(mother, father, etc)</small>	Lives with Student? Yes No
Martial Status: Married Single Separated Divorced Widowed	
Guardian Phone	Guardian Address if different than above
Guardian Work Place	Guardian Work Phone
Guardian Email	

EMERGENCY CONTACT

Emergency contacts are authorized to pick up students when GUARDIANS cannot be reached.

Emergency Contact Name	
Relationship to student: (mother, father, etc)	
Emergency Contact Phone	
Emergency Contact Work Place	Emergency Contact Work Phone

Emergency Contact Name	
Relationship to student: (mother, father, etc)	
Emergency Contact Phone	
Emergency Contact Work Place	Emergency Contact Work Phone

Emergency Contact Name	
Relationship to student: (mother, father, etc)	
Emergency Contact Phone	
Emergency Contact Work Place	Emergency Contact Work Phone

HEALTH/MEDICAL INFORMATION

Allergies or Reactions to: <input type="checkbox"/> <u>FOOD</u> please list _____ <input type="checkbox"/> Medications _____ <input type="checkbox"/> Other _____	Medical: <input type="checkbox"/> Asthma: Parent providing inhaler to office? YES NO <input type="checkbox"/> Diabetes <input type="checkbox"/> Convulsions/Seizures Explain _____ <input type="checkbox"/> Other medical information: _____
Parent providing EpiPen to office? YES NO	
Does your student take any medication regularly? YES NO Reason for medication _____	
Will your student need to take the medication during the school day? YES NO	

PREVIOUS SCHOOL ATTENDED

Name of last school attended	
Address, City, Zip	
Phone	Fax
Former place of residence	
Special Services received at previous school (please check all that apply)	<input type="checkbox"/> Special Education ("Permission to Place" form required) <input type="checkbox"/> Speech Therapy ("Permission to Place" form required) <input type="checkbox"/> Section 504 <input type="checkbox"/> Other Explain _____

OTHER CHILDREN IN HOME

Full Name	Date of Birth	Grade
Full Name	Date of Birth	Grade
Full Name	Date of Birth	Grade
Full Name	Date of Birth	Grade

MCKINNEY-VENTO ACT QUESTIONNAIRE

SECTION A <input type="checkbox"/> In a shelter <input type="checkbox"/> With more than one family in a house or apartment <input type="checkbox"/> In a motel, hotel, car or campsite <input type="checkbox"/> With friends or family members (other than parent/guardian) If you checked a box in Section A, complete Section B. <input type="checkbox"/> Choices in Section A DO NOT APPLY	SECTION B - ONLY COMPLETE IF YOU CHECKED A BOX IN SECTION A Is the living arrangement checked in Section A the result from a loss of housing or economic hardship? YES NO UNSURE The student lives with: <input type="checkbox"/> 1 parent <input type="checkbox"/> 2 parents <input type="checkbox"/> 1 parent & another adult <input type="checkbox"/> A relative, friend(s), or other adult(s) <input type="checkbox"/> Alone with no adults <input type="checkbox"/> An adult that is not the parent or legal guardian OFFICE USE ONLY <input type="checkbox"/> Student not covered by McKinney-Vento Act <input type="checkbox"/> Student covered by McKinney-Vento Act <input type="checkbox"/> Follow-up Required
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I affirm that as the legal guardian, all information provided is true and accurate.

Guardian Signature _____ Date _____

Mio AuSable Schools

Release of Student Records

Previous School	
Previous School Address	
Student Name	
Birthdate	Grade

Please send the above named student's complete school records including:

- Official administrative record, CA-60
- Official transcript (High School)
- Standardized achievement, aptitude and intelligence test scores
- Special education records (IEPC, diagnostic reports, medical records)
- Any other applicable student records

Signature of Parent/Guardian _____ Date _____

SEND ALL RECORDS TO:

Mio AuSable Elementary School 1110 W. 8th Street Mio, MI 48647 989-826-2430 phone 989-826-2417 fax	Grades K-5
Mio AuSable High School 1110 W. 8th Street Mio, MI 48647 989-826-2481 phone 989-826-2416 fax	Grades 6-12

For Office Use Only: Date Sent: _____ Date Received: _____

STATE BOARD OF EDUCATION APPROVED HOME LANGUAGE SURVEY*

Mio AuSable Schools is collecting information regarding the language background of each of its students. This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1151 – 380.1158 of the School Code of 1976, Michigan's Bilingual Education Law. Would you please help by providing the following information? Thank you very much for your cooperation.

Name of Student _____ Grade _____ Age _____

School Building: (please circle) Elementary or Middle School/High School

1. Is your child's native tongue a language other than English? Yes No

What is that language? _____

1. Is the primary language used in your child's home or environment a language other than English? Yes No

What is that language? _____

Signature of Guardian _____ Date _____

Mio AuSable 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.

I authorize Mio AuSable 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: _____

PARENT & ATHLETE CONCUSSION INFORMATION SHEET



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 bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY ATHLETE:

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not “feeling right” or is “feeling down”

SIGNS OBSERVED BY COACHING STAFF:

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

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. An athlete 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 or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.
2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most athletes 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.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

STUDENT-ATHLETE NAME PRINTED

STUDENT-ATHLETE NAME SIGNED

DATE

PARENT OR GUARDIAN NAME PRINTED

PARENT OR GUARDIAN NAME SIGNED

DATE

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