Please provide the name and relationship of the person completing the registration process for _____ below.

Name of person registering the student: _____

Your relationship to the student: _____

Date: _____

Please check one of the following:

☐ **I verify that my student's address has NOT changed for the 2023-24 school year**

☐ **My student's address has changed for the upcoming year.**
I understand that I will need to update that information on the following verfication page and upload proof of residence on step 5 of this registration process.

☐ **My student is new and I understand that I will need to upload a proof of residence document in step 5 of this registration process.**
(i.e. utility bill, tax return, bank statement, mortgage statement, rental/lease agreement, medical bill. Documentation must be dated within 60 days of enrollment)

Transportation:

Will the student be riding the bus to and from their home address? [ ]

Will the student be riding the bus to and from an alternate address? [ ]

Please provide the alternate address: _____

English Language Learner:

What is the student's native language? _____

Was your student receiving ELL services at their previous school? [ ]

Special Education:

Was your student receiving Special Education services at their previous school (IEP)? [ ]

Does your student have a 504 plan? [ ]

Agreements and Consents:

1. [ ] I have read the Notice Concerning Release of Directory Information without Parent Student Consent under FERPA.

2. [ ] I give permission for my child to participate in Communities in School of Indiana Programs and services in the school district while he she is enrolled in their current school.

[ ] Additionally, I give my permission to CIS of Indiana to photograph, film, video, and or make sound recordings of my student, to quote or publish statements of my student, and to use such photographs, films, video, sound recordings and or other statements for educational and promotional advertising materials.

3. [ ] I have read and agree to the Financial Responsibility agreement.

4. [ ] My student and I have read and agree to the iPad Agreement and the Student Acceptable Use Agreement.

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

Medical Emergency Information

Please fill out the most recent contact and medical information. This information will be used in case of an emergency at school.

Name: DOB:

I hereby give my permission for the school to obtain the services of any of the indicated physicians or hospitals in case the named student suffers illness or accident. It is also understood that the school will make an effort to contact a parent before action is taken. I understand that the medical information in this document may be shared with appropriate staff on a need-to-know basis to ensure the safety of my child.

*Parent Guardians Signature: *Date:

Please check if this student has any of the following conditions:
Please be aware that you are responsible for turning in to your school any recent action plans or doctors notes concerning these conditions.

☐Food Allergies ☐Medication Allergies ☐Bee Sting Allergy

☐Asthma ☐Diabetes 1 or 2 ☐Seizures

☐Bone or Joint Disorder ☐Heart Condition ☐Hemophilia or Sickle Cell

If you have checked any of the above conditions please describe and see the nurse for further paperwork (example: peanut allergy):

Please list any other medical diagnosis, surgeries or other health concerns that you would like the nurse to know:

Daily Medication and dosages (given at school and home):

☐I do not have a physician and would like information about local providers ☐I do not have medical insurance or Medicaid and would like further information

Community Health Network

Permission for School Nurse Services

The School Nurse program is staffed by nurses from Community Health Network. This is a School clinic, and not part of Community Health Network. All records are maintained by the School. There is no charge to you for the services. School nurses may provide non-emergency first aid treatment, emergency care, and conduct health screenings to students, without the return of this permission form. To approve use of clinic records to determine eligibility for the student to participate in school activities, and for additional healthcare services described in Section I, please return this form as well as a Request to Administer Medication form for any medication to be administered to the student. If your child has or needs a Plan of Care for recurring treatment, please also submit that information with this form.

School Year Beginning 2023: This consent is effective August 1, 2023 through August 1, 2024

***School:**
Student Name:
Student date of Birth:

I. Consent to Treat: I give permission for my student to receive additional health services from the school nurse clinic at his her school. I understand that nursing personnel cannot take care of all the health needs a student may have. The School nurse is available to assist you in locating health resources that may benefit your student.

I have read this information and understand what additional services the clinic may provide, which include, but are not limited to: (a) specialized treatment not considered an emergency, (b) Care prescribed by a physician or other qualified practitioner and established, through discussions with me, as a "Plan of Care" for my child, and (c) Referrals to health providers in the community. It is my responsibility to notify the clinic staff about changes in any Plan of Care, as well as changes in guardianship, the child's living or custody arrangements, and contact numbers.
If my child needs over the counter or prescription medications during the school day, I will complete and attach a "Request to Administer Medication" form for each medicine.

***Signature of Parent/Guardian:** *** Date:**
(or student if 18 or older)

Signature of Student (if 18 or older or emancipated): **Date:**

II. Release of Information: In addition to using health information about the student named above to treat the student s injuries and illnesses and for clinic administration, I hereby authorize the use and disclosure of the health information as needed to the applicable school administration or staff to evaluate the student s eligibility to participate in school activities, or to resolve grievances. In addition, I give my consent to the school-based health clinic staff to look at my child's full school record, including attendance, in order to provide information that may assist the clinic staff in helping my child. I understand that the clinic will not restrict services to the student based on my decision not to sign below for this Authorization, but that the student s participation in certain school sponsored activities may be conditioned on the signing of this Authorization.

***Signature of Parent/Guardian:** *** Date:**

Signature of Student (if 18 or older or legally emancipated): **Date:**
OR:
Form read to verified with parent guardian listed above, and verbal consent witnessed by school personnel
on

Termination of Permission: This Permission may be revoked in writing at any time prior to its expiration date, except to the extent that action has already been taken in reliance on this Authorization. Send or hand deliver a written revocation to a member of the clinic staff.

Community Health Network

Autorización para los Servicios de Enfermería Escolar

Se maneja el programa de Enfermería Escolar con enfermeras provenientes de Community Health Network. Esta es una clínica Escolar y no es parte de Community Health Network. El plantel escolar mantiene todos los registros. No le cobramos por los servicios. Las enfermeras escolares pueden proporcionarle tratamientos de primeros auxilios que no son de emergencia, atención de emergencia y conducir evaluaciones de la salud para los estudiantes, sin el regreso de esta autorización. Para aprobar la utilización de los registros de la clínica para determinar la elegibilidad que tenga el estudiante para participar en actividades escolares, y para los servicios ilimitados de enfermería, sírvase regresar este formulario como también el formulario para Solicitar la Administración de Medicamentos para que se puedan administrar al estudiante. Si su hijo tiene o necesita un Plan de Atención para tratamientos recurrentes también presente esa información con este formulario.

Año Escolar 2023 – Consentimiento efectivo de agosto 1, 2023 hasta agosto 1, 2024.

***Escuela:**

Nombre del estudiante:

Fecha de nacimiento del estudiante:

I. Consentimiento para Tratar: Yo doy consentimiento para que mi hijo reciba los servicios adicionales de salud de la clínica de su escuela. Comprendo que el personal de enfermería no puede encargarse de todos las necesidades de salud que mi hijo pueda tener. Sin embargo, si mi hijo no cuenta con el cuidado regular de un médico o clínica, yo me encargaré con la enfermera de escoger un proveedor.

Yo he leído esta información y comprendo cuáles son los servicios adicionales que la clínica puede proveer, que incluyen pero sin limitarse a: (a) Tratamiento de primeros auxilios que no son considerados emergencia, (b) Atención prescrita por un médico u otro practicante calificado y establecido, por medio de diálogos conmigo, como un "Plan de Atención" para mi hijo, y (c) Referencias a proveedores de salud en la comunidad. Es mi responsabilidad notificar al personal de la clínica sobre cambios en cualquier Plan de Atención como también cambios del menor relacionado al tutor legal, los arreglos de vivienda o de custodia y los números de contacto.

Si mi hijo necesita medicamentos con o sin receta durante el día escolar, completaré y adjuntaré un formulario de "Pedido para Administrar Medicamentos" para cada medicina.

***Firma** del Padre o Tutor Legal: *** Fecha:**
(si el estudiante es menor de 18 años)

Firma del Estudiante (si tiene 18, mayor o emancipado): **Fecha:**

II. Divulgación de Información: Además de usar la información de salud sobre el estudiante indicado arriba para tratar heridas y enfermedades del estudiante y para la administración de la clínica, por medio de ésta autorizo el uso y la liberación de la información de salud según sea necesario por la administración escolar o el personal correspondiente para evaluar la eligiblidad del estudiante para participar en las actividades escolares, o resolver quejas. Asimismo, doy mi consentimiento al personal de la clínica de salud para observar el registro escolar completo de mi hijo, incluyendo la asistencia, para obtener información que pueda capacitar al personal de la clínica para ayudar a mi hijo. Comprendo que la clínica no pondrá restricciones en los servicios al estudiante basado en mi decisión de no firmar esta Autorización abajo, pero puede que la participación del estudiante en ciertas actividades patrocinadas por la escuela dependa en la firma de esta Autorización.

Terminación de la Autorización: Se puede revocar esta Autorización por escrito a cualquier momento antes de la fecha de vencimiento salvo si se han tomado medidas en virtud de esta autorización. Envíe o entregue personalmente una revocación escrita a un miembro del personal de la clínica.

***Firma** del padre o tutor legal (estudiante menor de 18): *** Fecha:**

Firma del estudiante (18 o mayor, o legalmente emancipado): **Fecha:**

O:

Formulario leído a verificado con el padre tutor legal indicado arriba y testificado por el personal de la escuela el consentimiento verbal el (fecha que se obtuvo el consentimiento).

Virtual Care for MSD Decatur Township

Students who see the school nurse with an illness may escalate their care by seeing a Community Health Network Provider through *Virtual Care*. *Virtual Care* is essentially an online Doctor visit completed from the convenience of the nurses office. Strep throat, pink eye, rash or ear infection are all common illnesses that can be diagnosed by the team of health care professionals through *Virtual Care*. Once diagnosed, if a prescription is necessary, it can be sent to the pharmacy of the parents choice. By taking the provider to the student, we will eliminate the inconvenience for parents of taking their child out of school to head to the Doctor's office. This interaction with the health care provider only occurs if the student's parent or guardian have completed the consent form.

Community Health's Foundation will assist financially to make this cost neutral for all families during this pilot year as we hope families can take advantage of this opportunity if and when necessary. If you choose to participate, we ask that you complete and sign the parental consent form below to make your child eligible for these services.

Community Health Network Patient Consent Agreement

THIS PATIENT CONSENT AGREEMENT

THIS PATIENT CONSENT AGREEMENT applies to all services provided by Community Health Network, Inc., Community Hospital North, Community Hospital East, Community Hospital South, Community Heart and Vascular Hospital (a facility of Community Hospital East), Community Howard Regional Health, Community Hospital Anderson, Community Physician Network, Community Home Health, Community Surgery Center North, Community Surgery Center East, Community Surgery Center South, Community Surgery Center Hamilton, Community Surgery Center Northwest, Community Surgery Center Howard, Community Surgery Center Plus, Community Endoscopy Center Indianapolis, Community Digestive Center Anderson and Figleaf Boutique (each of these health care providers whether individually licensed or operating under the license of another hereinafter referred to collectively as "Community"). This Patient Consent Agreement covers all services provided by Community including, but not limited to, in-person, virtual, telephone and e-visit services.

Medical Treatment

I request or authorize Community to provide and perform under the direction of my physician(s) and or advanced practice provider(s) (each a "provider") and or his her designee such care, procedures, services and supplies as are considered advisable for my health and wellbeing. I am aware the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me by my provider(s) or Community as to the result of any treatments, examinations, procedures or other services provided by Community. I authorize Community to dispose of any tissue, severed or amputated member, body part, or medical device removed in connection with services provided by Community. I understand it is the responsibility of the provider to explain to me the nature of any diagnostic, therapeutic, medical and or surgical procedures necessary to treat me and to explain risks and consequences associated with the services.

Virtual Services

I understand Community may provide certain services virtually by remote telehealth technology ("virtual visit"). A virtual visit uses two-way audio and video communications in order for a provider to see my image on the screen and hear my voice to provide health care services, diagnosis, consultation, treatment, or education. These communications may use the Internet, local phone lines or wireless connections. The provider will determine whether my condition and or concern is appropriate for a virtual visit, and I understand there is no guarantee of diagnosis, treatment, or prescription. Further, I understand I may have to travel to see a provider in-person for certain diagnosis and treatment matters or if there are any issues or failures with the equipment or connection.

Patient Rights and Advance Directives

If I am receiving hospital inpatient services or ambulatory surgical center services, I acknowledge I have been given written materials on my patient rights and responsibilities, which include my right to an advance directive. For all other Community services, I understand that information about advance directives is available upon request.

Consent to Release Medical Records

I understand Community will make every effort to treat my medical record information as confdential; however, I realize information must be shared with other providers involved in my care or in the payment of my care. Further, I understand other healthcare providers involved in my care will have access to my medical information as permitted by state and federal law. I consent to the release of my medical information for treatment, payment and health care operational purposes as allowed by state and federal law, including the release of communicable disease information.

Legal Relationships

I understand my services may be provided by: (1) providers who are not employees of Community but who have a contract with Community to provide services, such as emergency physicians, anesthesiologists, radiologists, pathologists and other independent physicians; and (2) providers who have no employment or other contractual relationship with Community (collectively, "Independent Providers"); and these Independent Providers may or may not participate in my insurance plan. I understand Community is responsible for carrying out the instructions of such Independent Providers, but I acknowledge (a) Independent Providers are not employees or agents of Community; and (b) **Community is not responsible for the medical decisions, acts or omissions of Independent Providers.**

Communications

I authorize Community and its agents to contact me at any telephone number I provide to Community including wireless (cellular) telephone numbers by calling or text messages, which could result in charges to me. Methods of contact may include using pre-recorded artifcial voice messages and or use of an automatic dialing device, as applicable. I understand I will be able to opt out of text messages. Community and its agents may also contact me by email at any email address I provide.

Assignment of Insurance Benefits
If my insurance is accepted by Community, I assign payment to: (1) Community; and (2) Independent Providers involved in my care. I understand I will receive separate bills for services performed by Independent Providers who may or may not participate in my insurance plan. I understand Community verifies my benefits and or bills my insurance plan as a courtesy to me. I authorize Community to release to Medicare and its agents any information needed to determine my benefits for services received. I authorize the release of my medical records and any other information necessary to obtain payment from Medicare, Medicaid and other payers. I request that payment of authorized benefits from Medicare, Medicaid and other insurance plans be made on my behalf to Community for services provided by Community. Further, I understand verification of my benefits is not a guarantee the insurance plan will pay those benefits and I am responsible for ensuring that any prior authorization required for my services is obtained in advance of treatment. In addition, I hereby appoint Community and its employees and agents as my representative(s) to file grievances and appeals for me with my insurance plan as allowed by Indiana State law.

Responsibility for Payment
I understand that I may request and receive an estimate of anticipated charges. I understand and acknowledge: (1) an estimate is not a guarantee; (2) the estimate is not binding upon Community; and (3) actual charges will be determined based on the services I receive and may be more or less than the estimate. I understand I am financially responsible for all amounts not paid by insurance or other payers for services provided to me by Community and any Independent Providers and I agree to pay all charges when due or in accordance with any financial arrangement made at the time of discharge. Further, if I have overpaid on any account with Community, I agree that the overpayment may be applied to any outstanding charges on other Community accounts. I understand Community provides financial assistance and payment options to those who qualify. I understand if I opt out of using my insurance, I will not be eligible for financial assistance under Community's Financial Assistance Policy. I understand I can request additional information on payment options or financial assistance if I believe I may not be able to pay or may not be able to pay timely. In the event I do not pay such charges when due or I fail to comply with any payment arrangement, I agree to pay costs of collection, including attorney fees and interest and authorize Community or its agent to access my credit report.

Release of Responsibility for Valuables
I understand Community is not liable for personal possessions including, but not limited to, money, valuables, dentures, eyeglasses, hearing aids or other property, that are lost or damaged. I know Community has the right to search anything on its premises, including wallets and purses, for the safety and welfare of its patients and visitors. If Community decides an item could be a threat to health or safety, Community may: (1) dispose of it; (2) put it in a safe; or (3) give it to law enforcement. I know I can avoid having my possessions searched by sending them home.

Pictures and Recordings
I consent to closed circuit monitoring, videotaping, digital or audio recordings, photography and or images of my care for Community's internal purposes including, but not limited to, identification, clinical care, education, performance improvement and or safety related purposes. I understand I will be asked to sign a separate consent if a recording or image may be used for external purposes.

Receipt of Notice of Privacy Practices
I acknowledge that I have received or have been offered the Community Health Network Notice of Privacy Practices and understand I may also access a copy at www.eCommunity.com.

By signing below, I acknowledge that I have read and agree to pages 1, 2 and 3 of this Patient Consent Agreement and my questions have been answered. Changes will not be accepted to this Patient Consent Agreement. Everything in this Agreement continues and does not expire or terminate. I understand that I can request a copy of this Agreement.

Name of Student: _____ **Student Date of Birth:** _____

Patient/Legal Representative: _____ Date: _____

Relationship: _____ **Parent/Legal Representatice Phone #:** _____

Telehealth Visit Permission
The school nurse has my permission to initiate a telehealth visit with a Community Health Network (CHNw) provider for my student if the school nurse deems it to be of benefit to address an acute illness such as a sore throat. There is no cost to me for conducting this visit. The nurse will contact me prior to the visit but if they are unable to reach me, they will try to reach others authorized to consent for health care for my child. If when we reach you or an authorized adult, your student will be registered into the CHNw system and you will be able to participate remotely in the telehealth visit. Records of the exam will become part of the Community Health Network provider's record, and available through their office.

Over-the-Counter (OTC) Medications Available for use in the School Nurse Clinic with Telehealth Visit
The school nurse will participate in the visit, and if recommended by the CHNw provider, may administer the following over-the-counter (OTC) medications from the supply available in the school nurse office, during the school day. Please check which medications you approve of the provider ordering to give to your student. If nothing is checked below we will not administer any of the OTC below, unless you consent during the telehealth visit. Check all that apply.

- ☐ Acetaminophen
- ☐ Ibuprofen
- ☐ Saline Solution
- ☐ Eye Wash
- ☐ Contact Lens Solution
- ☐ Tums chewable tablets
- ☐ Calamine Lotion
- ☐ Vaseline
- ☐ Wound Irrigation
- ☐ Throat Lozenge - Luden's or equivalent

Add'l Parent Guardian Name: _____ Add'l Parent Guardian Phone #: _____

If your student has a telehealth visit and a prescription is ordered by the Community Health Network Provider, list the pharmacy where the prescription should be sent

Pharmacy Name: _____ Pharmacy #: _____
Pharmacy Location: _____

Residence Information

In accordance with the McKinney-Vento Homeless Education Act, you have the right to all educational services provided in Decatur Township including the following: special education services, gifted and talented, and after school activities. You further have the right to receive transportation to and from school for the duration of your temporary residency, free meals at school, and free textbooks. All of these rights are afforded to you during the duration of your temporary residency.

You are required to inform the school district of any changes in address including when you find permanent housing. You must also provide some kind of contact information for the school district to reach you.

If it is found that falsified information has been given to the school district, your rights as stated above will be terminated as well as your eligibility for the McKinney-Vento program. If you are in dispute of the decision regarding your eligibility for the McKinney-Vento program or transportation of your child to and from school you have the right to appeal the decision but contacting the McKinney-Vento liaison and you will be encouraged to complete the dispute resolution process.

Student: **Student DOB:**

Parent/Guardian:

***School:**

Phone: **Email:**

Address:

***Is this student part of the Foster Care system? (please type YES or NO)**

***Is your current address Temporary?** YES ☐ NO ☐

***Is your current address Permanent?** YES ☐ NO ☐

***Please choose which of the following situations the student currently resides (you can choose more than one):**

☐ House

☐ Motel, car or campsite

☐ Sharing the housing of friends or family members (other than parent guardian)

☐ Shelter or other temporary housing

If you are living in shared housing, please check all of the following reasons that apply:

☐ Economic Situation

☐ Temporarily waiting for house or apartment

☐ Providing care for family member

☐ Living with boyfriend girlfriend

☐ To enable child to attend school in MSD Decatur Township

☐ Loss of employment

☐ Parent guardian deployed

☐ Student under the age of 18 and living without your parent(s) guardian(s)

☐ Other (please explain):

By signing below, I acknowledge that I have received and understand the above rights.

***Parent/Guardian/Unattached Youth Signature:**

Military Children in Education

Purpose: This questionnaire is the result of a Department of Defense (DOD) program supported by Indiana statute 20-19-3-9.4. Confidentially identifying military children and providing data on their attendance and educational outcomes, states can assist schools and districts by providing access to data to help inform policy and program decisions for this unique student population. In addition, DOD will benefit from this data in developing policy for military child education initiatives.

*School Name: [ ]

Student's Full Legal Name: [ ]

Please complete the questions that best describes your student's situation. It is possible to answer "yes" to both.

*1. Is the above named student connected to an Active Duty military parent guardian? ☐ Yes ☐ No

Meaning a school-aged child, enrolled or in the process of enrolling in KG-12th grade, is claimed as a dependent by an Active Duty member of the Armed Forces of the United States; or the student and an Active Duty member(s) are of the same household whether or not the active duty member(s) claims the student as a dependent. "Active Duty" means: full-time duty status in the active uniformed service of the United States.

*2. Is the above named student connected to a Guard or Reserve military parent guardian? ☐ Yes ☐ No

Meaning a school-aged child, enrolled or in the process of enrolling in KG-12th grade, who is claimed as a dependent by a member of the National Guard or Reserve; or the student and National Guard or Reserve member(s) are of the same household whether or not the National Guard or Reserve member(s) claims the student as a dependent. "National Guard or Reserve" means: members of the Reserve Component as defined in 10 U.S.C. Section 10101. Includes Army National Guard of US, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard of US, Air Force Reserve or Coast Guard Reserve.

*Signature: [ ] *Date: [ ]

This form shall be handled by schools in a confidential manner in accordance with IDOE Guidance (IC 20-19-3-9.4)

Indiana Department of Education

Dr. Katie Jenner, Secretary of Education

The Migrant Education Program (MEP) provides supplemental education and support services to eligible children through national funding. The purpose of the program is to ensure that all migrant students reach the academic standards and graduate with a high school diploma (or complete a GED/HSE).

WORK SURVEY

Thank you for answering the following questions. If your child is eligible for the Migrant Education Program, they may receive additional educational support. This information is **strictly confidential.**

Student's Name: _____ Parent's Name: _____

Address: _____

Telephone: _____

*Date: _____ *Parent Signature: _____

1. * Within the last **3 years**, have your children) moved for any reason? *Please type YES or NO: _____

2. * Has anyone in your household moved from one one school district to another with the United States to look for seasonal or temporary work in agriculture? * Please type YES or NO: _____

If you answered **NO** to either of these questions, please STOP save the form and move to the next registration step.

If you answered **YES**, please continue

3. When was the last time you or anyone in your household has moved to look for, or work in an agricultural activity within the United States?
Month _____ Year _____

4. Please check any of the agricultural activities listed below that you have looked for or worked in:

- ☐ Plant or harvest vegetables or fruits
- ☐ Detassel corn
- ☐ Tobacco farm
- ☐ Poultry and or egg farm
- ☐ Duck, turkey, chicken, pork or beef processing plant
- ☐ Aquaculture fish hatcheries
- ☐ Canning vegetables or fruits
- ☐ Sod farm
- ☐ Planting, pruning or cutting trees
- ☐ Dairy farm
- ☐ Flora culture gladiola farm
- ☐ Green house or plant nursery

Please list the names of all of the children in the household under 22 years of age.

	Child's Name	Date of Birth
1.		
2.		
3.		
4.		
5.		