



Welcome to Lakewood! Enclosed are the registration forms to be completed for your student(s). Below is a list to assist you in the registration process. Please return all enrollment materials to the building your student will be attending.

STUDENT REGISTRATION CHECKLIST

_____ Fill out all enrollment forms

-
- Student Registration Form
- Record's Request Form
- Home Language Survey
- Concussion Form
- Permission to Place – *Only required if student receives special education services.*

_____ Obtain Certified Birth Certificate Copy

State law requires that a certified birth certificate copy (with raised seal) be presented as proof of age for your student. Certified birth certificates were available from the county clerk in the county in which your child was born. **Law requires that a state or county certified original be presented at registration. No copies will be accepted. As the law states, we cannot accept birth certificate copied and transferred from another school.** If you need assistance obtaining your student's birth certificate, please contact the school's secretary. Phone numbers can be found in this packet on the request for records form.

_____ Updated Immunization Record

By law, all waivers must be obtained directly from your county health department. Check to see your child has had the following immunizations:

_____ Proof of residency

- _____ own or rent – Documents required - driver's license with current address and/or utility bill
- _____ living with another family – Documents required - driver's license with a letter from owner of house in which you are living. Appointment required with McKinney-Vento Director, Keith Carpenter, (616) 374-8842.
- _____ other – Court documents may be accepted.



Vaccines Required for School Entry in Michigan

Whenever children are in group settings there is a chance for disease to spread. Children must follow vaccine laws in order to attend school. These laws are the minimum standard for preventing disease outbreaks in group settings. The best way to protect children from serious diseases is to follow the recommended vaccination schedule at cde.michigan.gov/vaccines. When following the recommended schedule children are fully protected and any school vaccination requirements are met.

	All Kindergarteners and 4-6 year old transfer students	All 7th Graders and 7-18 year old transfer students
Diphtheria, Tetanus, Pertussis (DTP, DTaP, Tdap)	4 doses DTP or DTaP 1 dose must be at or after 4 years of age	4 doses diphtheria and tetanus or 3 doses if 1 st dose given on or after 1 year of age 1 dose Tdap at 11 years of age or older upon entry into 7 th grade or higher
Polio	4 doses or 3 doses if dose 3 was given on at or after 4 years of age	
Measles, Mumps, Rubella (MMR)*	2 doses at or after 12 months of age	
Hepatitis B*	3 doses	
Meningococcal Conjugate (MenACWY)	None	1 dose at 11 years of age or older upon entry into 7 th grade or higher
Varicella (Chickenpox)*	2 doses at or after 12 months of age or Current lab immunity or History of varicella disease	

*If the child has not received these vaccines, documented immunity is required. All doses of vaccines must be valid (current, unexpired) and signed for school entry purposes. These rules apply to children who are the above ages upon entry into school. During disease outbreaks, incompletely vaccinated children may be excluded from school. Parents and guardians choosing to decline vaccines must obtain a verified non-medical waiver from a local health department. Read more about waivers at www.michigan.gov/cde. The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity, or expression, political beliefs, or disability. Rev. 6/2022



if



**Lakewood
Public Schools**

REQUEST FOR RECORDS

Name of Previous School _____

Address _____

City, State, Zip _____

Telephone Number _____ Fax Number _____

Parent/Guardian Signature _____

Student's Name _____	Grade _____	Birth Date _____
Student's Name _____	Grade _____	Birth Date _____
Student's Name _____	Grade _____	Birth Date _____
Student's Name _____	Grade _____	Birth Date _____

This is to certify that the parent/guardian of the above named students request release of **ALL** of the following information to the school indicated below:

Discipline Records

Medical/Health Information

Teacher Reports (grades, attendance, achievement, test records, etc.)

Special Education, IEP, etc

Psychologist and/or Social Worker Reports

Current school program/recommendations

PLEASE SEND RECORDS TO:

LAKEWOOD ELEMENTARY

Grades 1st - 4th

Student Records Department

812 Washington Blvd., Lake Odessa, MI 48849

Phone (616) 374-8842

Fax (616) 374-1499

email: penningtonj@lakewoodps.org

LAKEWOOD EARLY CHILDHOOD CENTER

Grades Preschool - Kindergarten

Student Records Department

223 W. Broadway, Woodland, MI 48897

Phone (269) 367-4935

Fax (269) 367-4771

LAKEWOOD HIGH SCHOOL

Grades 9th - 12th

Student Records Department

7223 Vette Road, Lake Odessa, MI 48849

Phone (616) 374-8868 Fax (616) 374-1477

LAKEWOOD MIDDLE SCHOOL

Grades 5th - 8th

Student Records Department

8699 Brown Road, Woodland, MI 48897

Phone (616) 374-2400

Fax (616) 374-2424

According to the Final Regulation-Family Educational Rights and Privacy Act (Final Rule on Education Record, Federal Register, June 18, 1976, Vol. 41, No. 118, 24673), it is **no longer necessary to obtain written consent to release records between schools**. It states that school officials, including parents within the educational institution and officials of other school systems in which the student may intend to enroll, may receive a students' record without written consent for such release.

REQUEST FOR RECORDS SENT ON ____/____/20____ BY _____, Building Registrar



Student Registration Form

School Use Only:

Student #:	
UIC #:	
<input type="checkbox"/> MICR	<input type="checkbox"/> Honeywell
<input type="checkbox"/> Spec. Ed	<input type="checkbox"/> 504
Homeroom:	

Student Information: Please print

Last:	First:	Middle:
Address (no PO Boxes):		
City:	State: Michigan	Zip:
County of Residence: <input type="checkbox"/> Barry <input type="checkbox"/> Eaton <input type="checkbox"/> Ionia <input type="checkbox"/> Kent		Township of Residence:
Mailing Address (if different):		
Home Phone:		Birth City:
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Birth date: / /
Grade Entering:		

SPECIAL NEEDS of new student enrolling if any:

(circle all that apply) Vision Hearing Speech Allergies Special Education Medications

Medical Conditions:

student have an IEP or 504 Plan at previous school ☐ Yes ☐ No If yes, complete the Permission to Place form attached to enrollment packet.

Ethnicity

Is this student Hispanic/Latino? (Choose only one)

☐ No, not Hispanic/Latino

☐ Yes, Hispanic/Latino-(A person of Cuban, Mexican, Puerto Rican, South/Central American, or other Spanish culture or origin, regardless of race.)

Race

The question to the left is about ethnicity, not race. No matter what you selected, please continue to answer the following by marking one or more boxes indicated what you consider your student's race to be.

☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ White

☐ Asian American ☐ Black/African American

School most recently attended:		City & State		Last Grade Completed:	
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Family Information: (check the best answer)	Own or Rent	Living w/ another family	Shelter	Hotel/Motel	Unknown	Other Location	Temporary Location
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Student resides with:

Name	Relationship
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Parent/Guardian - A:	Birth date:
Address:	
City:	State:
Zip:	
Home Phone:	Work Phone:
Cell Phone:	E-Mail Address:
Employer & Occupation:	

Parent/Guardian - B:	Birth date:
Address:	
City:	State:
Zip:	
Home Phone:	Work Phone:
Cell Phone:	E-Mail Address:
Employer & Occupation:	

Step-parent - A, Court Appointed Guardian or Case Worker Information if applicable:

Name:	Birth date:	
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Cell Phone:	E-Mail Address:	
Employer & Occupation:		

Step-parent - B, Court Appointed Guardian or Case Worker Information if applicable:

Name:	Birth date:	
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Cell Phone:	E-Mail Address:	
Employer & Occupation:		

Emergency Information: (Family member/friend to contact after your home/work has been tried.)

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:

Please list all children in the family even if they are not in school.

Name:	Grade:	Birth date:
Name:	Grade:	Birth date:
Name:	Grade:	Birth date:
Name:	Grade:	Birth date:
Name:	Grade:	Birth date:
Name:	Grade:	Birth date:

Transportation Information

Will this student ride the bus to school from	Home	Childcare	Neither	(please circle one)
Will this student ride the bus from school to	Home	Childcare	Neither	(please circle one)

If applicable:

Childcare Provider's Name:	Phone:
Address (NO PO Boxes):	City/Zip:

Parent/Guardian Signature:	Date:
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FOR SCHOOL USE ONLY:

School assigned to:	LHS	LMS	LES	LECC
Sent to School & Transportation:	/ /			
Parent anticipating call with information for schooling and transportation information?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Transportation	Yes <input type="checkbox"/> No <input type="checkbox"/>	School

Lakewood Public Schools Emergency Contact Information 2024-2025

Student Name: _____

Please list three (3) people who will assume temporary care of your child if **you cannot be reached** (note: these contacts will be called in the order you list them). **PLEASE ADD PARENT NAME TO THIS LIST.**

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I hereby grant Lakewood Public Schools permission to photograph/video my child as they deem necessary for school use and/or public media release. YES / NO (please circle)

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements deemed necessary.

Allergies: _____

Do any of the above allergies require use of an Epi-Pen if exposed to or ingested? YES / NO (circle one), if yes please see the office.

Does your student have Asthma: YES / NO (circle one) Will your student have an inhaler at school: YES / NO (circle one), if yes please see the office.

Other Conditions: _____

Medications: _____

Primary Care Physician: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature of Parent / Guardian: _____ Date: _____

Office Use Only

Date Entered: _____

PERMISSION TO PLACE

IF YOUR STUDENT RECEIVED SPECIAL EDUCATION SERVICES PLEASE COMPLETE THE BOX BELOW

Student Name	Birthdate	Grade
Parent Guardian Name	Phone #	
Previous School District		

FOR OFFICE USE ONLY

First day of attendance: _____ Date of Parent Consultation: _____

Student Transferred from: Inside County Out of County Out of State

Use the Current IEP from the previous school district: Y N

Current IEP date: _____ Date of Initial/Reeval IEP: _____

Primary Disability: _____

Program/Service	Amount of time & frequency	Actual hours	Teacher

Other options or factors considered?

Why did you not select those services?

Building Administrator Signature

Date

Enrollment Form Questions for Identification of English Learners, Immigrant Students, and Migratory Students:

Home Language Survey Questions

Is your child's native (first) tongue a language other than English?

- Yes
- No

What is the other language? _____

¿Es el idioma nativo (primer idioma) de su hijo/hija otro aparte del inglés?

- Si
- No

¿Cuál es ese idioma? _____

Is the primary language used in your child's home or environment a language other than English?

- Yes
- No

What is the other language? _____

¿Es el idioma principal usado en la casa o "barrio" de su hijo/hija un idioma diferente al inglés?

- Si
- No

¿Cuál es ese idioma? _____

Immigrant Student Identification

Where was your child/student born? State _____ Country _____

If your child/student was born outside of the U.S., then when did the child/student enter the country? _____

¿Dónde nació su hijo/hija/estudiante? Estado _____ País _____

¿Si, su hijo/hija/estudiante nació en un país diferente a Estados Unidos, cuando fue que su hijo/hija/estudiante llegó a Estados Unidos? _____

Migratory Student Identification

Have you or a family member worked in agriculture, poultry, dairy, and/or packing house in the last 3 years or 36 months?

- Yes
- No

If yes, where did you work? _____ Date: _____

¿A usted o alguien en su familia trabajado en agricultura, una lechería, o con animales como pollos o cerdos en los últimos 3 años?

Si, su respuesta es sí. Cuando _____ y Donde _____

Medicaid Annual Notification Regarding Parental Consent

Background:

Since 1993, the State of Michigan has participated in a Federal program called Medicaid School-Based Services. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Although this partial reimbursement is available only for students who are Medicaid eligible, services are provided to all students with disabilities regardless of their Medicaid eligibility status.

The Michigan School-Based Services program is under the direction of the Michigan Department of Community Health.

In 2013, the regulations regarding Medicaid parental consent for School-Based Services changed. Prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification. So what does all this mean?

Is there a cost to you?

NO – IEP/IFSP services are provided to students while they are at school at NO cost to the parent/guardian.

Will School-Based Medicaid claiming impact your family's Medicaid benefits?

The School-Based Services program does NOT impact a family's Medicaid services, funds, or limits. Michigan operates the School-Based Services program differently than the family's Medicaid program. The School-Based Services program does not affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?

- | | | |
|-------------------------------|------------------------------|------------------------------------|
| • Evaluations | • Psychological/Social Work | • Case Management |
| • Speech & Language/Audiology | • Orientation & Mobility | • Personal Care |
| • Occupational Therapy | • Assistive Technology Svcs. | • Special Education Transportation |
| • Physical Therapy | • Nursing | |

What type of information about your child will be shared?

In order to submit claims for School-Based Services reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?

Information about your child's School-Based Services may be shared with the Michigan Medicaid agency and its affiliates for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?

You have the right to withdraw consent to disclose your child's personally identifiable information to the Michigan Medicaid agency and its affiliates at any time.

Will your consent or refusal affect your child's services?

NO. Regardless of whether you have Medicaid coverage or not (and whether you provide consent or not) the school district will still provide services to your child pursuant to their IEP or IFSP.

What if you have questions?

Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

Consent for Medicaid School-Based Services

Student Name: _____

Birth Date: _____

School District: _____

The Medicaid School-Based Services Program in Michigan:

- Provides partial reimbursement to school districts for services such as Occupational Therapy, Physical Therapy, Speech Therapy, Psychological Services, Social Work, Orientation and Mobility, Transportation, Nursing, Case Management and Assistive Technology Services.
- Does NOT affect a family's Medicaid insurance benefits and there is NO cost to the family, now or in the future.
- Helps school districts to offset some of the costs of health care provided to children.
- Is voluntary and requires a parent or guardian to provide written consent to release information about their child to the Michigan Medicaid agency and its affiliates to obtain reimbursement. This may include name, address, date of birth, student ID, Medicaid ID, disability, dates and services delivered.

If your child receives any of the services listed above and qualifies for Medicaid benefits at any time during the school year, we request your permission to release information to enable your school district to access School-Based Medicaid Reimbursement. The consent remains in effect from the beginning of the current school year until it is withdrawn. You have the right to withdraw this consent at any time by notifying your school district in writing. If you do not provide consent, the district will still provide the services at no cost to you.

By signing below, I understand and agree that _____ and its local districts may access my child's public benefits or insurance information in order to seek reimbursement for services rendered as listed on the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP).

I have also received a copy of the Medicaid Annual Notification Regarding Parental Consent.

DATE: _____

Signature of Parent/Guardian: _____

August 2024



RE: Student Safety "Drop Off Locations"

To: Parents and Guardians of Lakewood Elementary Students

It is preferred that each of our students have the same end of the day routine.

(ie. They get on the bus everyday) If your family is requesting to have multiple end of the day routines, please fill in below. (Possible reasons for choosing this option- custody, employment responsibilities, etc.)

Student: _____

Teacher: _____

Monday : ☐ My child will be walking home/sitter after school
☐ I will pick my child up after school
☐ My child will ride _____'s bus (Animal Name: _____)
to this address: _____

Tuesday: ☐ My child will be walking home/sitter after school
☐ I will pick my child up after school
☐ My child will ride _____'s bus (Animal Name: _____)
to this address: _____

Wed: ☐ My child will be walking home/sitter after school
☐ I will pick my child up after school
☐ My child will ride _____'s bus (Animal Name: _____)
to this address: _____

Thurs: ☐ My child will be walking home/sitter after school
☐ I will pick my child up after school
☐ My child will ride _____'s bus (Animal Name: _____)
to this address: _____

Friday : ☐ My child will be walking home/sitter after school
☐ I will pick my child up after school
☐ My child will ride _____'s bus (Animal Name: _____)
to this address: _____

Parent Signature

Date

LAKEWOOD PUBLIC
SCHOOLS
223 West Broadway
Woodland, Michigan
48897 616.374.8043
www.lakewoodps.org

LAKEWOOD ELEMENTARY
812 Washington Blvd
Lake Odessa, MI 48849

KEITH CARPENTER, PRINCIPAL
Phone 616.374.8842
Fax 616.374.1499



Food Service



Michigan Department of Education
Office of School Support Services

CACFP REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant.

1. School/Agency Name:	2. Site Name:	3. Site Telephone:	
4. Name of Participant/Student:		5. Participant Age:	
6. Name of Parent/Guardian:		7. Parent/Guardian Telephone:	
8. Check One: <input type="checkbox"/> Participant has a disability or a medical condition and <i>requires</i> a special meal or accommodation. (Refer to instructions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. One of the following licensed medical professionals must sign this form: licensed physician (MD or DO), physician's assistant (PA), or nurse practitioner (NP). <input type="checkbox"/> Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. A licensed physician (MD or DO), physician's assistant (PA), registered dietitian nutritionist (RDN), nurse practitioner (NP) or speech pathologist must sign this form. <input type="checkbox"/> Participant <i>does not have a disability</i> , but is requesting a special accommodation for a fluid milk substitute that meets the USDA nutrient standards for non-dairy beverages offered as milk substitutes. Granting the request of a non-dairy milk substitute is at the discretion of the facility. A licensed physician, physician's assistant, registered dietitian nutritionist, nurse practitioner, or parent/guardian may sign this form.			
9. Disability or medical condition requiring a special meal or accommodation:			
10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:			
11. Diet prescription and/or accommodation: <i>(please describe in detail to ensure proper implementation- use extra pages as needed)</i>			
12. Foods to be omitted and substitutions: <i>(please list specific foods to be omitted and suggested substitutions; you may attach a sheet with additional information as needed.)</i> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">A. Food(s) To Be Omitted:</div> <div style="width: 45%;">B. Suggested Substitution(s)</div> </div> <div style="border-bottom: 1px solid black; height: 20px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-top: 5px;"></div>			
13. Indicate Texture: <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed			
14. Adaptive Equipment:			
15. Signature of Preparer:	16. Printed Name:	17. Telephone:	18. Date
19. Signature of Medical Authority:	20. Printed Name: (include credentials)	21. Telephone	22. Date



Michigan Department of Education
Office of School Support Services

REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS INSTRUCTIONS

1. **School/Agency Name:** Print the name of the school or agency that is providing the form to the parent.
2. **Site Name:** Print the name of the site where meals will be served (e.g., XYZ school, XYZ child care center, XYZ family day care home, etc.).
3. **Site Telephone:** The telephone number of site where meal will be served. See #2.
4. **Name of Participant/Student:** Print the name of the child or adult participant to whom the information pertains.
5. **Participant Age:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent/Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Parent/Guardian Telephone:** Print the telephone number of parent or guardian.
8. **Check One:** Check a box to indicate whether participant has a disability, does not have a disability or does not have a disability but is requesting special accommodation for fluid milk substitution.
9. **Disability or medical condition requiring a special meal or accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.).
10. **If participant has a disability, provide a brief description of participant's major life activity affected by the disability:** Describe how the physical or medical condition affects the participant. For example: "Allergy to peanuts causes a life-threatening reaction."
11. **Diet prescription and/or accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
12. **Food(s) to be omitted and suggested substitution(s):** List specific foods that must be omitted. For example, "exclude fluid milk." List specific foods to include in the diet. For example, "Nutritionally equivalent non-dairy beverage."
13. **Indicate texture:** Check a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. Examples may include: sippy cup, large handled spoon, wheel-chair accessible furniture, etc.
15. **Signature of Parent/Guardian:** Signature of parent/guardian requesting the accommodation.
16. **Printed Name:** Print name of parent/guardian completing form.
17. **Date:** Date parent/guardian signed form.
18. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
19. **Printed Name with Credentials:** Print name of medical authority, including credentials.
20. **Telephone:** Telephone number of medical authority.
21. **Date:** Date medical authority signed form.

Disability Definition: The Americans with Disabilities Act Amendment Act defines a "disability," in part, as a physical or mental impairment that substantially limits a major life activity or major bodily function of an individual. (For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008). More Information regarding the ADAAA, which expanded the definition of disability, see the [Comparison of ADA and ADAAA sheet](http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf) (<http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf>).

Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: [USDA-Office of Assistant Secretary for Civil Rights](http://www.ascr.usda.gov/complaint_filing_cust.html) (http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.



LAKESWOOD PUBLIC 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 LAKESWOOD PUBLIC 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: _____

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

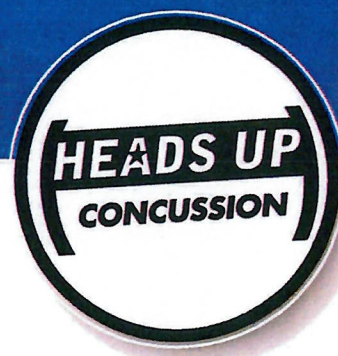
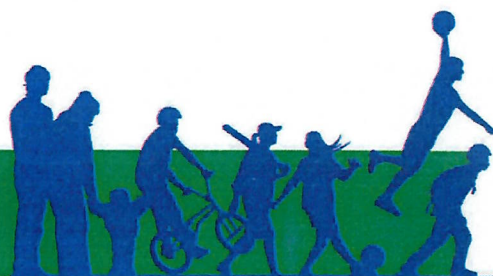
DATE

JOIN THE CONVERSATION ➞ www.facebook.com/CDCHeadsUp

TO LEARN MORE GO TO ➞ WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

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

Michigan Department
of Community Health



Rick Snyder, Governor
James K. Haveman, Director

► **"IT'S BETTER TO MISS ONE GAME
THAN THE WHOLE SEASON"**

PLEASE REMOVE THIS PAGE, COMPLETE THE FORM AND RETURN TO SCHOOL

Student _____ **Grade** _____ **Teacher** _____

Acknowledgement of Handbook

I have received the handbook and acknowledge that I am aware of the following policies and procedures as outlined in the hand book.

Volunteer Driver Assurance

According to district policy 8600, when parents or adult's volunteers assist in the transportation of pupils, whether school-owned or private vehicles, the school district must reassure itself and the parents of the students involved that the drivers are over 21 years old, have a valid driver's license, are covered by insurance, have a good driving record, and will require that all occupants in the vehicle wear seat belts in accordance with Michigan law.

Your signature on page 24 verifies that you meet the following criteria as outlined in the policy.

- ◆ I am over the age of 21.
- ◆ I have a valid Michigan's driver's license
- ◆ I have no known medical condition which could cause me to have seizures or blackouts while driving.
- ◆ I have coverage by an insurance policy that is in force and has not expired.
- ◆ I have a driving record that is free of major moving violations.
- ◆ I will make certain that all student occupants in the vehicle wear seat belts in accordance with Michigan law.
- ◆ All safety features (brakes, horn, lights, and tires) on my vehicle are in good working order.

I understand that according to Michigan No-Fault law, my personal insurance would be the first to cover myself and the students that I am transporting. **Only if and when the limits of my personal insurance are exhausted would the school district's insurance provide coverage beyond my own.** My signature on this form indicates knowledge and acceptance of this fact.

If any of the situations above should change, I will notify the school before transporting students.

Computer/Internet/Technology Use Agreement

We have read the rules regarding Computer/Internet/Technology use in the handbook. The student signature indicates that the student agrees to abide by the rules established. The parent signature indicates an understanding that students will face disciplinary action for violating the rules.

Students are not allowed to use the computers until they agree to the rules. If there is a problem with those rules, please discuss them with the building principal.

Early Dismissal

Occasionally, it becomes necessary to close school early due to inclement weather or other unforeseen circumstances. In the event that this happens, the announcement will be posted on our web page as well as announced on WBCH and WION radio stations.

I would be interested in being part of the school community by:

- ☐ volunteering in the classroom
- ☐ sharing my knowledge about _____ in a classroom
- ☐ helping with classroom parties
- ☐ being an active member of the parents group
- ☐ being a mentor to a student in need
- ☐ volunteering to tutor students after school
- ☐ teaching an after school class about _____
- ☐ reading to a class of students
- ☐ talking about my job as a _____ to a classroom
- ☐ serving on a building improvement committee
- ☐ working on a school beautification work day

My and my student's signature below verifies the following:

- Acknowledgement of Handbook
- Release of Information
_____ Yes _____ No
- Volunteer Driver Assurance
- Computer/Internet/Technology Use Agreement
- Permission to participate in intra district field trips and local points of interest (i.e. high school play, community library, park, etc.)

Name of Student

Student Signature

Parent Phone Number

Parent Signature

Parent Email Address

Please fill out the front and back of the backpack tag below. Please list your name and anyone else that has permission to pick up your student.

STUDENT NAME

Grade your student will be in
for the 2024/2025 school year

_____ 1st Grade

_____ 2nd Grade

_____ 3rd Grade

_____ 4th Grade

NAME **EVERYONE** THAT
CAN PICK UP YOUR
STUDENT **INCLUDING** Parents/Guardian



It's more than a meal application.

We strongly encourage all parents/guardians to submit a Meal Application. Completing an application takes less than 10 minutes, and parents only need to complete one Meal Application.

Meal Applications may be downloaded from our website. Additionally, families may complete meal applications online. Once you submit an application, your child/children will receive free or reduced-price meals.

EVERY ELIGIBLE FORM COUNTS!

Every eligible form that is not submitted means lost resources for our schools.

Filling out the School Meal Application may help provide:



Lakewood Public Schools
8/01/2024

Dear Parents and Guardians:

Please take a moment to complete the form and return it to your student's school. The Education Benefits Form collects information needed to ensure the school receives state and federal funding for education programs. **Without this information, Lakewood Public Schools could lose important funding for education programs that our students need.** These supplemental grants and programs have the potential to offer supports and services for our students including, but not limited to:

- Instructional staff (ex. Reading Interventionists, Math Tutors, Academic & Behavior Aids)
- Teaching supplies and materials
- Counselors and Social Workers
- Professional Learning for staff
- Parent and Community engagement supplies and activities
- Technology

Why is Lakewood requesting financial information? The Education Benefits Form determines eligibility of a student or household. The total count of eligible students is used to determine the funding amounts that will be made available to a school. The more forms returned the better.

What do I need to do? Please complete the attached form and return it to any **Lakewood Public Schools office or mail to Traci Brewer, 8699 E Brown Rd Woodland, MI 48897**

How will this information be protected? In keeping with current practices, **all forms are keep in a file cabinet locked in the Food Service Directors Office.**

What else might my student or household be eligible for? Based on the information you provide on your Education Benefits Form; your child may qualify for other programs such as: Pay to play or Pay to Participate

- Programs that provide food support
- Programs that provide assist with school testing fees
- Programs that provide help with sports fees
- Potential household support for cable and internet-possibly through your carrier

You must complete the **Sharing Information with Other Programs form**, included in the packet or at any school office, to grant permission for your eligibility information to be shared.

If you have any questions, please contact **Traci Brewer at 616 374-2415.**

Sincerely,

Principal or Superintendent

INSTRUCTIONS FOR COMPLETING THE EDUCATION BENEFITS FORM

This form is used to determine eligibility for state benefits for which your child(ren)'s school may qualify. Please complete, sign, and return this form to your child's school.

If any member of your household receives benefits from the Food Assistance Program (FAP), Family Independence Program (FIP), or FDPIR, please follow these instructions:

Part A: Student Information – For each student in the household Pre-K through 12th grade, list the last name, first name, grade level, school, and H if homeless, M if Migrant, R if Runaway or F if a Foster Child.

Part B: Benefits Received – If any household member, including adults, receives Food Assistance Program (FAP), Family Independence Program (FIP), or Food Distribution Program on Indian Reservations (FDPIR), provide the name and case number. Bridge Card Numbers and Medicaid Numbers are NOT ACCEPTABLE case numbers.

Part C: Household Size - Check the box for the total number of individuals living in your household. This should include all children and adults, related and un-related, that live in a single dwelling and share income and expenses.

Part D: Annual Household Income – Skip this part

Part E: Certification - Sign the form. Print your name and date.

If your household does not receive benefits from the Food Assistance Program (FAP), Family Independence Program (FIP), or FDPIR, please follow these instructions:

Part A: Student Information - For each student in the household Pre-K through 12th grade, list the last name, first name, grade level, school, and H if homeless, M if Migrant, R if Runaway or F if a Foster Child.

Part B: Benefits Received – Skip this part

Part C: Household Size – Check the box for the total number of individuals living in your household. This should include all children and adults, related and un-related, that live in a single dwelling and share income and expenses.

Part D: Annual Household Income – Moving across the same row as the household size check box, check the box that shows the range of annual income for all people in your household. Make sure to include all of the following income sources: work, welfare, child support, alimony, pensions, retirement, Social Security, SSI, VA benefits, child income and/or all other income. The amount should be before any deductions for taxes, insurance, medical expenses, child support, etc.

Part E: Certification - Sign the form. Print your name, date, and contact information.

EDUCATION BENEFITS FORM SY 2024 - 2025

District: _____

School: _____

Part A: STUDENT INFORMATION - Complete for each student Pre-K through 12th Grade

Student's Last Name	Student's First Name	Grade Level	School	Identify H if Homeless M if Migrant R if Runaway F if Foster

Part B: BENEFITS RECEIVED (if applicable)

If any member of your household receives Food Assistance Program (FAP), Family Independence Program (FIP), or FDPIR, provide the name and case number for the person who receives benefits. Bridge Card Numbers and Medicaid Numbers are NOT ACCEPTABLE case numbers.

Name: _____ Case Number: _____

Part C: HOUSEHOLD SIZE	Part D: ANNUAL HOUSEHOLD INCOME - Select the appropriate range of combined annual income for all people in the household (Include all income before taxes)		
<input type="checkbox"/> 1 →	<input type="checkbox"/> At or below \$19,578	<input type="checkbox"/> Between \$19,579 and \$27,861	<input type="checkbox"/> At or above \$27,862
<input type="checkbox"/> 2 →	<input type="checkbox"/> At or below \$26,572	<input type="checkbox"/> Between \$26,573 and \$37,814	<input type="checkbox"/> At or above \$37,815
<input type="checkbox"/> 3 →	<input type="checkbox"/> At or below \$33,566	<input type="checkbox"/> Between \$33,567 and \$47,767	<input type="checkbox"/> At or above \$47,768
<input type="checkbox"/> 4 →	<input type="checkbox"/> At or below \$40,560	<input type="checkbox"/> Between \$40,561 and \$57,720	<input type="checkbox"/> At or above \$57,721
<input type="checkbox"/> 5 →	<input type="checkbox"/> At or below \$47,554	<input type="checkbox"/> Between \$47,555 and \$67,673	<input type="checkbox"/> At or above \$67,674
<input type="checkbox"/> 6 →	<input type="checkbox"/> At or below \$54,548	<input type="checkbox"/> Between \$54,549 and \$77,626	<input type="checkbox"/> At or above \$77,627
<input type="checkbox"/> 7 →	<input type="checkbox"/> At or below \$61,542	<input type="checkbox"/> Between \$61,543 and \$87,579	<input type="checkbox"/> At or above \$87,580
<input type="checkbox"/> 8 →	<input type="checkbox"/> At or below \$68,536	<input type="checkbox"/> Between \$68,537 and \$97,532	<input type="checkbox"/> At or above \$97,533

*** Special Instructions for households with more than 8 people: DO NOT check the boxes above. Instead, fill in items below:**

Household size (# people): _____ Total annual income: _____

Part E: CERTIFICATION - The head of household or adult designee who completed this form must complete this certification section

I certify (promise) that all information on this form is true and that all income is reported to the best of my knowledge. I understand that this form may impact the amount of State or Federal funding allocated to my local school district. I understand that the information I have provided may be verified.

(Signature) _____ (Printed Name) _____ (Date) _____

(Address) _____ (City) _____ (Zip) _____

(Email Address) _____ (Home Phone) _____ (Work Phone) _____

Do NOT fill out this section. This is for school use only.

Status: F _____ R _____ N _____ Determining Official's Signature: _____ Date: _____

Sharing Information with Other Programs

Dear Parent/Guardian:

Based on the information you gave on your Education Benefits Form; your child may qualify for other programs. For the following programs, we must have your permission to share your information. Sending in this form will not change whether your children get free (or reduced-price meals, if applicable).

Yes! I **DO** want school officials to share information from my Education Benefits Form with:

- ☐ Pay to Participate (Athletics and Clubs).
- ☐ Programs that provide food support.
- ☐ Programs that provide school supplies or assist with school testing fees.

If you check "Yes" to any or all the boxes above, please fill out the form below. Your information will be shared only with the programs you checked.

Child's Name: _____ School: _____
Child's Name: _____ School: _____
Child's Name: _____ School: _____
Child's Name: _____ School: _____

Printed Name: _____ Address: _____

Signature of Parent/Guardian: _____ Date: _____

For more information, you may call Traci Brewer @ 616 374-2415.

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: [USDA Program Discrimination Complaint Form](#), from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
2. fax: (833) 256-1665 or (202) 690-7442; or
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.

USDA Civil Rights Complaint Link:

<https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>

Return this form to: *Any Lakewood Public Schools office or Traci Brewer@8699 E Brown Rd, Woodland, MI 48897*