CASS CITY PUBLIC SCHOOLS

NEW STUDENT REGISTRATION

If Living in the Cass City School District:

- Complete the forms included in this packet
- Must have a certified birth certificate of the student enrolling *(Cannot accept a copy)*
- Must have a complete immunization record
- If you are an active athlete, bring information which will help in transferring schools. Ex: completed physical
- Proof of residency

* *Turn in the above completed information to Cass City Jr/Sr High School then:*

- Make an appointment by calling 989-872-2148 to see Dean of Students - Mrs. Hempton for the 2025-2026 school year.

If living out of School District (School of Choice)

- Complete the appropriate form provided in the office.
- This must be approved by the superintendent before registering.

CASS CITY JR./SR. HIGH SCHOOL
REQUEST FOR SCHOOL RECORDS

Student Name _____ Date of Birth _____ Grade _____

Previous School Attended: _____

Address: _____

_____
Phone Fax

Records requested:

- → Attendance Information (include dates of withdrawal)
- → Health Records & Immunization Record
- → Discipline History
- → Test Scores
- → UIC Code
- → Transcript (also include student's grades to date, which include the period since the last grade report through the withdrawal date)
- → Special Education Files & Psychological files

- **PLEASE FAX TRANSCRIPT TO 989-872-2068 TO EXPEDITE OUR PROCESS.**

In sending this form, we are requesting information about one of your former students. Before we formally enroll the student, we are requesting that you answer the questions below about the above student.

1. Has the above named student been suspended or expelled from your school district?____
   If yes, please explain:_____
2. Is disciplinary action pending against this student?_____If yes, please explain:___
   _____
3. Was this student in a special education program in your school district?_____
   If yes, please give student's current placement:_____
4. Student's last date of entry to your school?_____

Parent Release Form: As parent or legal guardian for the above named student, I hereby authorize the release of all school records to Cass City Jr./Sr. High School and request that they be sent to the above address at your earliest convenience.

According to the Final Regulations-Family Educational rights & Privacy Act (Buckley Amendment) dated 6-17-76, it is no longer necessary to obtain written consent to release records. It states that school officials, including teachers within the educational system in which a student intends to enroll, may receive a students record without parental consent for such release.

_____
Parent/Guardian Signature Date

PLEASE SEND RECORD TO:

Cass City Jr./Sr. High School
4868 North Seeger St
Cass City, Michigan 48726
Attn: Guidance

Cass City Public Schools Registration Form

Date:_____

Student Name:_____ Gender:_____

Male *Female*

Address:_____ Grade:_____

_____ Birthdate:_____

Birthplace:_____ Enrollment Date:_____

City *State* *1st day student will attend school*

Social security # _____ _____ _____

Ethnicity: Is this student Hispanic or Latino *(Circle one)*

Race: *(use %'s to rank ethnic groups that apply)*

_____ Asian American

_____ Black or African American

_____ White

_____ Native Hawaiian or Other Pacific Islander

_____ Native American or Alaska Native

Tribal Affiliation _____

Has your child been enrolled in special education classes?___Yes ___No

*If yes, *complete the attached temporary placement form*

Parent's email address: _____

Needed for family access and teacher correspondence

Residency Information:

Is the student a resident of Cass City Public Schools? ___ Yes ___ No

If Not, Have you applied through school of choice? ___ Yes (attach copy of application) ___ No

What district do you live in?_____County_____Township_____

Where is the student living now? Check one:

○ in a one family dwelling
○ in a car
○ in a shelter
○ unaccompanied youth
○ foster child
○ in a RV park or campsite
○ in a motel or hotel
○ with more than one family in a house or apartment
○ with friends/family (other than parent/guardian)
○ ward of court
○ other _____

With whom does the student reside: _____

Ex: mother/father, mother/stepfather, father/stepmother, foster parent, grandparents, aunt/uncle, friend of family

Does student need transportation? If so, name crossroads: _____

Pick up address:_____ on _____ (days of week)

Drop off address: _____on _____ (days of week)

District Transferring From: _____

School Name *Address* *Phone #* *Fax #*

Brought in copy of Immunizations ○yes ○no Brought in copy of Birth Certificate ○yes ○no

Does your child have any medical alert information: Including: allergies ○ asthma ○ diabetes ○

Other ○ Explain:_____

Parent/Guardian information: WHERE STUDENT RESIDES:
Head of household

Guardian 1 Name:_____ Relationship to student:_____

Primary Phone #: _____ E-Mail address: _____

Guardian 2 Name:_____ Relationship to student:_____

Primary Phone #: _____ E-Mail address: _____

Marital Status: _____

Married/Divorced/Single

Guardian 1 Employer's Name _____Guardian 2 Employer's Name_____

Work Phone # _____ Work Phone # _____

Is either of your parent/guardian in the military? _____Yes ___No Relationship:_____Branch: _____

_____ ● _____ ● _____ ● _____ ● _____ ● _____ ● _____ ● _____ ● _____

Parent/Guardian information: For divorced, separated or non-custodial parents/guardians

Guardian 1 Name:_____ Relationship to student:_____

Primary Phone #: _____ E-Mail address: _____

Guardian 2 Name:_____ Relationship to student:_____

Primary Phone #: _____ E-Mail address: _____

Marital Status: _____

Married/Divorced/Single

Guardian 1 Employer's Name _____Guardian 2 Employer's Name_____

Work Phone # _____ Work Phone # _____

*Home Address : _____

Street *City* *Zip code*

_____ ● _____ ● _____ ● _____ ● _____ ● _____ ● _____ ● _____ ● _____

Emergency contacts: Family/friends in case of emergency and cannot contact parent/guardian

Name: _____ Relationship to student: _____

Home Phone: _____ Cell Phone: _____

Emergency contacts: Family/friends listed in case of emergency and cannot contact parent/guardian

Name: _____ Relationship to student: _____

Home Phone: _____ Cell Phone: _____

This form has been completed by _____

Signature *Relationship*

Tuscola ISD

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

Tuscola Intermediate School District
1385 Cleaver Road, Caro, MI 48723 989-673-2144

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 **Tuscola ISD** 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.

Signature of Parent/Guardian: _____

Date: _____

ORIGINAL SIGNED COPY MUST BE RETURNED TO TIFFANY BEHRENDS, TUSCOLA ISD CENTRAL OFFICE

Cass City Public Schools

4868 North Seeger Street
Cass City, MI 48726
Phone: 989-872-2200
Fax: 989-872-5015
www.casscityschools.org

Learning from the past.
Making the most of the present.
Preparing for the future.

For the purposes of birth date certification as stated in Michigan Public Act 84 of 1987.

I, _____, do swear or affirm that

_____ was born on _____
(month, date, year)

and that I am unable to furnish a certified copy of the student's birth certificate for the following reason(s):

_____

_____

_____

_____

_____

_____ _____
Signature Date

Subscribed and sworn to before me on
This_____day of _____,20___.

Notary Public in and for the County of
_____, State of Michigan. My
commission expires:_____.

MISSION STATEMENT
All School personnel will accept the responsibility to provide the opportunity for all students to be productive in a global society.

Cass City Public Schools
No Child Left Behind

STATE BOARD OF EDUCATION APPROVED
HOME LANGUAGE SURVEY*

The school district 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 Section 380.1152-380.1157 of the School Code of 1995. 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_____

1. Is your child's native tongue a language other than English?

   _____YES _____NO What is the language? _____

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

   _____YES _____NO What is the language? _____

_____ _____ _____

Signature of Parent or Guardian Address Date

"Primary language" means the dominant language used by a person for communication.
*Translation of this survey form in Spanish, Arabic, French, Italian and Ojibwa is available at the Office of Field Services at 517-373-6066.

Tuscola Intermediate School District

McKinney-Vento Rights Notification

Date:_____

Name of Student:_____
Unaccompanied Youth: _____ YES _____ NO

Name of Father:_____

Name of Mother:_____

Name of Guardian:_____

Under the McKinney-Vento Assistance Act the following rights apply to youth/families in transition:

- Youth in transition are those who lack a fixed, regular, and adequate nighttime residence.
- Youth in transition have the right to attend either the local school or the school of origin, if this is in the best interest of the student.
- Youth in transition have the right to receive transportation to and from the school of origin
- Youth in transition have the right to enroll in school immediately, even if missing records and documents normally required for enrollment (birth certificate, immunizations).
- Youth in transition have the right to have access to the same programs and services that are available to all other students including transportation and supplemental educational services.
- Youth in transition have the right to attend school with children not experiencing transitional housing difficulties; segregation based on a student's status as "youth in transition" is prohibited.

Under this Act, the student has the right to attend the following school districts, as well as any public school academy with openings in the attendance area:

School of Origin: _____

School of Residence: _____

The following transportation options to the School of Origin are offered to this student:

_____

My signature indicates that these rights have been offered and explained to me on the date above. I have received a copy of this information.

Student Signature (if age appropriate):_____

Parent Signature:_____

Parent Signature:_____

Guardian Signature:_____

Liaison Note: *This information is given to parents and youth via the school district liaison upon enrollment and during parent teacher conferences twice per year or while enrolled.*

Liaison Signature:_____

School District:_____

Educational Material for Parents and Students (Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health. CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

UNDERSTANDING CONCUSSION

Some Common Symptoms

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

WHAT IS A CONCUSSION?

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

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

IF YOU SUSPECT A CONCUSSION:

1. **SEEK MEDICAL ATTENTION RIGHT AWAY** – A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.

2. **KEEP YOUR STUDENT OUT OF PLAY** – Concussions take time to heal. Don't let the student return to play the day of injury and until a heath care professional says it's okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.

3. **TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION** – Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

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

CONCUSSION DANGER SIGNS:

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

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

HOW TO RESPOND TO A REPORT OF A CONCUSSION:

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

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

To learn more, go to www.cdc.gov/concussion.

Parents and Students Must Sign and Return the Educational Material Acknowledgement Form

CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

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

_____	_____
Participant Name Printed	Parent or Guardian Name Printed
_____	_____
Participant Name Signature	Parent or Guardian Name Signature
_____	_____
Date	Date

Return this signed form to the sponsoring organization that must keep on file for the duration of participation or age 18.

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

Cass City Public Schools

Consent for Disclosure of Personally Identifiable Information and 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 student's name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information and immunization 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 Cass City Public Schools to release my child's immunization record and personally identifiable information 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: _____

Media Opt-Out Form for Parents

Cass City Jr/Sr High School
4868 N. Seeger Street
Cass City, MI 48726
Phone: (989) 872-2148
Email: [Email Address]

Purpose of Form:

This form allows parents/guardians to opt their child out of participation in photographs, video recordings, or audio recordings intended for use in publications, websites, social media, or other promotional materials by Cass City Public Schools.

Student Information:

- **Full Name of Student:** _____
- **Grade/Teacher:** _____
- **Date of Birth:** _____

Parent/Guardian Information:

- **Name:** _____
- **Phone Number:** _____
- **Email Address:** _____

Opt-Out Agreement:

By signing this form, I **DO NOT** give permission for Cass City Jr/Sr High School to:

☐ Photograph my child
☐ Video record my child
☐ Audio record my child
☐ Use my child's image, name, or voice in:

- Printed materials (e.g., brochures, flyers)
- Website or social media posts

- News media coverage
- Internal or external communications

This opt-out request is valid for the current school year only and must be renewed annually.

Acknowledgment and Signature:

I understand that by submitting this form, I am opting my child out of all media use as specified above. I understand that it is my responsibility to discuss this decision with my child and that the school/organization will make reasonable efforts to exclude my child from media, but cannot guarantee total exclusion (e.g., in group photos at public events).

Parent/Guardian Signature: _____
Date: _____

For Office Use Only:

Received by: _____
Date Received: _____

☐ **Noted in student record**
☐ **Teacher notified**
☐ **Communications team notified**

RED HAWK WELLNESS CENTER

ASPIRE RURAL HEALTH SYSTEM

Tittabawassee Area Psychological Services

Parent/Guardian Consent Form

The goal of the student health center is to meet the physical, social, and emotional health needs of students. Improving health will improve their learning. Our services support family values and relationships as much as possible.

SERVICES: Red Hawk Wellness Center provides the following:

- Health education
- Group & Individual Counseling
- Help filling out insurance forms.
- Referrals to other agencies
- Nursing Services
- Fitness Assessments & Wellness screenings

Services <u>not provided</u> at the Student Health Center include:

- Dispensing daily prescription medication (continue to follow the policies in your child's school handbook)
- Substance abuse counseling or intensive psychotherapy
- The Center <u>DOES NOT</u> dispense, prescribe, or otherwise distribute family planning drugs and /or devices; provide abortion services or referrals for abortion services.

PARENTAL/GUARDIAN CONSENT

If a signed consent form is on file, your child will be able to receive the services listed below. By law and center policy, your child will not receive these services without consent to the extent permitted by law. Care in emergency situations will be provided without consent with parental notification to follow. Whenever a student receives services on a walk in basis (i.e. Tylenol for a headache) staff will attempt to notify parent or legal guardian by phone or will send a written note with the child. Emergency contacts will only be notified when parents can't be reached and medical conditions warrant such (i.e. student must be picked up and /or needs physician assessment). A message will not be left on an unidentified voicemail/machine. If you have questions about the following services, please contact Mrs. Schuette or Ms. Gudenau at 989-912-1829.

Check yes next to the services you would like your child to receive <u>if needed.</u>

Yes ☐ No ☐ Social/Emotional Health Counseling (i.e. bullying, anger/stress management, depression, friendship skills, etc.)

Yes ☐ No ☐ Nursing Services (<u>If Yes complete medical history</u>) (i.e. headache, stomach ache, injury, first aid, etc.)

<u>NOTES:</u> The center will follow federal and state laws that allow minors to obtain specific services. The center will make referrals for mental health, substance abuse, family planning, HIV/AIDS testing, Sexually Transmitted Diseases, and child abuse as outlined in state laws. Parent involvement in these situations is highly encouraged by staff. It is the responsibility of the student or parent/guardian to follow-up with referrals and to pay for those <u>referral services.</u>

I have reviewed and understand the services offered by the Red Hawk Wellness Center. I give consent for my child to receive the services indicated in this document. By signing this consent form, I certify that I am the legal guardian and legal custodian of

Child's Name _____ Grade _____ School _____

This consent form will remain active until my child no longer qualifies for services due to age or location or until I withdraw my consent in writing. I understand that I can withdraw my consent for services at any time by providing written notice to my child's school.

I authorize the Red Hawk Wellness Center to share my treatment information with my primary care provider, other health professionals, and school staff as needed for coordinating care and services in compliance with applicable laws (e.g. HIPPA, FERPA, Michigan Statutes for Governing Minors Rights).

I acknowledge that I have received the RHWC's Notice of Privacy Practices.

_____ _____

Signature of parent/guardian Date

(Please turn over and complete) ⟹

Child's name (Last, first, middle initial)		Date of birth:	
Age:	Gender:	Grade:	Phone Number:
Home Address:	City:	Zip:	
Email address:			
Race/Ethnicity: ☐ Black/African ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic/Latin ☐ American Indian/Alaskan Native ☐ Asian			
Parent(s)/Gaurdian(s) Name: ☐		Phone Number:	
Primary Care Provider:		Phone number:	
Insurance: ☐ Medicaid ☐ Blue Cross/Blue Shield ☐ Other ☐ Uninsured– (☐ I would like to be contacted regarding Medicaid Enrolment ☐ I would not like to be contacted.)			

Daily Medications: Please list any medications your child takes regularly.

Name of Medicine	Dose (mg)	Frequency	Name of Medicine	Dose (mg)	Frequency
1)			3)		
2)			4)		
Allergies to medications:					

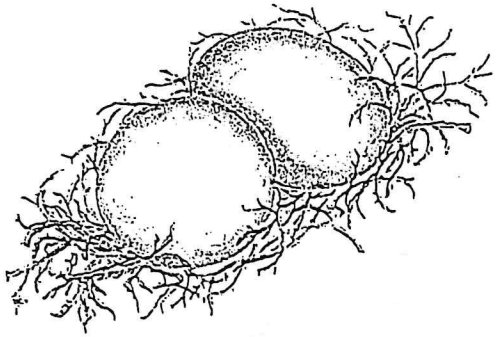
Over-the-counter (OTC) Medications: Please indicate if your child may receive OTC medications as needed.

Name of OTC Medication	Yes	No	Name of OTC Medication	Yes	No	Name of OTC Medication	Yes	No
Acetaminophen (Tylenol)			Cough Drops			Calamine lotion		
Ibuprofen (Motrin)			Triple Antibiotic Ointment			Oragel/Anbasol		
Benadryl			Hydrocortisone			Lotrimim cream		
Tum(s) Chewable			Benadryl cream			Sunscreen		

Child's Health History: If any of these conditions apply, please x in the Yes column.

Condition:	Yes	Condition:	Yes	Conditions:	Yes	Condition:	yes	Condition:	Yes
Bee sting allergies		Seizure/Epilepsy		ADD/ADHD		Bowel Disorders		Liver problems	
Food allergies		Asthma		High blood pressure		Mental health		Kidney problems	
Seasonal allergies		Diabetes		Fainting		Heart problems		Bleeding disorders	
Do you carry an Epi-Pen		Anemia		Shortness of breath		Stomach problems		Other	

Red Hawk



NEST EGG

Planning and Saving for the Future

The Red Hawk NEST EGG is a program enhancing postsecondary culture and financial support by

1.) implementing activities to increase child and family goal setting, career planning, and financial capabilities; and

2.) providing each student attending the Cass City Public Schools with a long-term savings account that can be used toward college or trade school expenses.

Planning for the Future

The NEST EGG develops a postsecondary culture by focusing on goal setting, career planning, and financial strategies. These outcomes will be achieved through

- on-going postsecondary conversations with children, families, and community;
- K-12 curriculum enhancements;
- parent and family workshops; and
- mentoring of elementary students by high school students and of high school students by community alumni of colleges/trade schools they plan to attend.

Saving for the Future

The NEST EGG assists with postsecondary financial support by providing a long-term savings account for every Cass City Public Schools (CCPS) student and working to "make saving a habit." During the 2020-2021 school year, savings accounts were opened (unless opted out by the family) for all current kindergarten through twelfth grade students. After 2020-2021, each kindergarten and new CCPS student will be given a savings account.

Each savings account is opened with a $50 deposit from Cass City PROMISE at Thumb Bank & Trust ($10) and the Sanilac County Community Foundation ($40). Each account is deposit only until students graduate from Cass City High School.

Red Hawk NEST EGG is automatically opened with $50 deposit

+

Child earns additional savings through incentives, fundraising, and deposits

=

Red Hawk NEST EGG available for a college or trade school

A Children's Savings Account (CSA) is More than Just the Money...

*Children with just $500 or less saved for college are 3 times more likely to go to college and 4 times more likely to graduate than those without savings.

*CSAs improve childhood development and academic performance.

*Parents and children with early savings have greater college expectations.

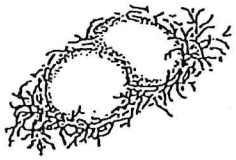
*CSAs increase a child's future financial capability.

*SOURCE: CFED Fact Sheet 2016

Cass City PROMISE

"Helping Red Hawks Soar Higher"

Frequently Asked Questions About the Red Hawk NEST EGG



What is the Red Hawk NEST EGG?

The Red Hawk NEST EGG is a program aimed at 1) helping students prepare for their future, and 2) providing financial support for saving for postsecondary education (continued learning after high school graduation). Future preparation for continued learning after high school will be developed by on-going conversations with children, families, and the community; curriculum enhancements; parent and family workshops; and mentoring of all students throughout their school careers. The financial support involves a long-term savings account that can be used toward college or trade school expenses.

Beginning in the 2020-2021 school year, every full-time student attending Cass City Public Schools will be automatically given a NEST EGG savings account—free! Each savings account will be opened at Thumb Bank & Trust with a $10 gift from the Cass City PROMISE. An additional $40 gifted by the Cass City PROMISE will be held at the Sanilac Community Foundation and released for use when a CCHS graduate attends postsecondary education. Over time, the balance of the Thumb Bank & Trust grows through private donations and various annual incentives.

Do I own the account?

No. The Cass City PROMISE is the owner of the account, but the funds are held in trust for you when you need them for college or trade school.

Does my account earn interest?

Yes. Your account at Thumb Bank & Trust earns interest.

How is my interest paid to me?

Any interest earned will be credited to your NEST EGG account.

Is there a minimum balance to open the account?

No. The Cass City PROMISE will make your first $10 deposit.

What fees will be charged to my account?

Your account is not subject to balance or transaction fees.

Cass City Promise Fund

Opt – Out Form

Please note: Your child will be automatically enrolled in this program unless you complete and return this form to the Elementary or Jr/Sr High School office.

Student Name: _____ _____

_____ _____

I/We choose to NOT participate (opt-out) of the CC Promise Fund Program

_____ _____

Parent or Guardian Signature Date

_____ _____

Parent or Guardian Signature Date

Return your completed Opt – Out form to the school where your child is enrolled.

Optional: Please let us know why you have elected not to participate in the automatic enrollment of your child in the CC Promise Fund program.

_____

_____

_____

If you have questions, please contact Superintendent Allison Zimba

(989) 872 – 2200 or the Sanilac County Community Foundation (810) 638 – 3634.

FOR OFFICE USE ONLY

Date Received _____ Received By _____

Cass City Jr. / Sr. High School

Release of Information Consent Form

CHILD: _____ DOB: _____

PURPOSE: In order to plan for and provide the best possible care for you and your child, various health professionals will need to share information. This is an authorization for the release of that information between various health professionals to be involved in the care plan of your family.

AUTHORIZATION: I hereby authorize the following persons, agencies and/or Multi-Agency Team to engage in written or verbal communication of my child. I understand this information will remain confidential and will be released only between the agencies designated below with a "yes."

The agencies authorized to exchange information include:

_____ HeadStart
_____ Department of Human Services
_____ Health Department
Tuscola Behavioral Health Systems
____ Tuscola ISD
____ Dr. _____

_____ Caro Community Hospital
_____ Covenant Hospital
_____ St. Mary's Hospital_____ _____
_____ McLaren Hospital
____ Dr._____

The following types of records may be released:

_____ Psychological testing
_____ Social/Developmental records
_____ Health/Medical records
_____ Occupational/Physical therapy
_____ _____

_____ Vision/Hearing reports
_____ Current IEP
_____ Current MET with Psychological Rpt.
_____ Student's CA-60 File
_____ _____

DURATION: I am aware that I can withdraw this authorization at any time. Unless withdrawn, this authorization shall remain in effect for one year from the date this form is signed.

AUTHORIZATION: The information exchanged between the designated agencies may include and is not limited to: information about communicable diseases and serious communicable diseases and infections as defined by statute and infections as defined by statutes and Michigan Department of Public health Rules. This includes venereal diseases (VD), tuberculosis (TB), hepatitis B, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) and AIDS related complex (ARC) or other as described. I understand that my protected health information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my protected health information will no longer be protected by the law.

SIGNATURE AUTHORIZATION: My signature means I have read this and/or have had it read to me in language I can understand.

_____
Signature of Client/Parent/Legal Guardian Date

_____
Street Address City, State, Zip Phone

_____
Witness Agency Date