

Central Massachusetts Collaborative

Student Registration Packet FY23

STUDENT INFORMATION

First Name: _____ Middle Name: _____

Last Name: _____ Gender: _____ DOB: _____

Grade: _____ Last School Placement _____ Student's Town of Residence: _____

Student's Birth City: _____ Student's First/Native Language: _____

Student's Language of Instruction: _____

Foster Placement: _____ Homeless Youth: _____

Student address/living arrangements, if different than parent/guardian: _____

Student's Phone Number: _____

Student's Email Address: _____

PARENT/GUARDIAN #1 CONTACT INFORMATION

First Name: _____ Last Name: _____ Gender: _____

Email Address: _____

Workplace: _____ Relationship to Student: _____

Legal Status: (Circle one) *Legal Guardian & Ed signer* *Legal Guardian only* *Educational signing rights only* *Other*

Address: _____ Zip Code: _____

Home #: (_____) _____ Cell #: (_____) _____ Work #: (_____) _____

Primary Language of the Contact: _____ Requires Translation: Yes No

Does the guardian have the right to dismiss the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian have the right to receive the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian live with the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian receive student's mail?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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Student Information Form (Continued)

PARENT/GUARDIAN #2 CONTACT INFORMATION

First Name: _____ Last Name: _____ Gender: _____

Email Address: _____

Workplace: _____ Relationship to Student: _____

Legal Status:(Circle one) *Legal Guardian & Ed signer* *Legal Guardian only* *Educational signing rights only* *Other*

Address: _____ Zip Code: _____

Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Primary Language of the contact: _____ Requires Translation: Yes No

Does the guardian have the right to dismiss the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian have the right to receive the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian live with the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian receive student's mail?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

PARENT/GUARDIAN #3 CONTACT INFORMATION

First Name: _____ Last Name: _____ Gender: _____

Email Address: _____

Workplace: _____ Relationship to Student: _____

Legal Status:(Circle one) *Legal Guardian & Ed signer* *Legal Guardian only* *Educational signing rights only* *Other*

Address: _____ Zip Code: _____

Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Primary Language of the Contact: _____ Requires Translation: Yes No

Does the guardian have the right to dismiss the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian have the right to receive the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian live with the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian receive student's mail?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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Student Information Form (Continued)

EMERGENCY CONTACT #1 INFORMATION

First Name: _____ Last Name: _____ Gender: _____

Email Address: _____

Workplace: _____ Relationship to Student: _____

Legal Status:(Circle one) *Legal Guardian & Ed signer* *Legal Guardian only* *Educational signing rights only* *Other*

Address: _____ Zip Code: _____

Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Primary Language of the Contact: _____ Requires Translation: Yes No

Does the guardian have the right to dismiss the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian have the right to receive the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian live with the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian receive student's mail?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

EMERGENCY CONTACT #2 INFORMATION

First Name: _____ Last Name: _____ Gender: _____

Email Address: _____

Workplace: _____ Relationship to Student: _____

Legal Status:(Circle one) *Legal Guardian & Ed signer* *Legal Guardian only* *Educational signing rights only* *Other*

Address: _____ Zip Code: _____

Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Primary Language of the Contact: _____ Requires Translation: Yes No

Does the guardian have the right to dismiss the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian have the right to receive the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian live with the student?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the guardian receive student's mail?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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Agency Involvement Form

Please input all agency information below. Each agency listed must also have a completed *Authorization to Release Information Form*.

AGENCY #1 INFORMATION

Agency Name: _____ Contact Person: _____

Agency Address: _____

Phone Number: _____ Relationship to Student: _____

Email Address: _____

Does the contact have the right to dismiss the student? Yes No

Does the contact have the right to receive the student? Yes No

Authorization to release information completed? Yes No

AGENCY #2 INFORMATION

Agency Name: _____ Contact Person: _____

Agency Address: _____

Phone Number: _____ Relationship to Student: _____

Email Address: _____

Does the contact have the right to dismiss the student? Yes No

Does the contact have the right to receive the student? Yes No

Authorization to release information completed? Yes No

AGENCY #3 INFORMATION

Agency Name: _____ Contact Person: _____

Agency Address: _____

Phone Number: _____ Relationship to Student: _____

Email Address: _____

Does the contact have the right to dismiss the student? Yes No

Does the contact have the right to receive the student? Yes No

Authorization to release information completed? Yes No

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Initials of Student (Page 2 of 2)

Receipt of CMC Student Handbook

The Central Massachusetts Collaborative (CMC) sets forth a high level of expectations for student achievement, conduct, and effort. The rules contained within this handbook pertain to student actions on and off the school grounds during the school year and during school-related situations, including transportation to and from school. These policies also apply to after-school and summer programs.

CMC considers violation of the Weapons Policy, found within this booklet, to be a serious matter. Please review this policy with your child/youth, as well as the other policies included within this booklet.

By signing below, I indicate that I have read the CMC Student Handbook and understand the policies and procedures therein. I understand that violation of these policies may result in disciplinary action. I understand that the student indicated below is responsible for these rules for the duration of their enrollment within Central Massachusetts Collaborative schools.

The student handbook is located on the CMC website, www.cmasscollaborative.org. There is also a copy at the school.

Student Name: _____

Student Signature: _____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____

Date: _____

Central Massachusetts Collaborative

School Media Policy

I hereby authorize and give my consent that the Central Massachusetts Collaborative and their representatives shall have the right to copyright, publish or use any and all photographic portraits or pictures, movie films including internet websites, computer / internet images, videotapes, and / or sound recordings taken or made of my student while attending the Central Massachusetts Collaborative and any program associated with the Central Massachusetts Collaborative for any lawful purpose. I understand that my student's name may be released in conjunction with the above.

Student Name: _____

- I consent to the above School Media Policy.
- ✓ I hereby understand the images of my student will not be used for financial gain.
 - ✓ I hereby waive all claims for any compensation for such use or for damages incurred by such use.
 - ✓ I hereby waive any rights I may have to inspect and/or approve the images that may be used.
- I **do not** consent to the above School Media Policy.

Parent/Guardian Signature: _____ Date: _____

School Class Picture Form

Student Name: _____

- Yes, I give permission for my student to be included in the group class picture which will be sent home to each student in class.
- No, I **do not** give permission for my student to be included in the group class picture which will be sent home to each student in class.

Parent/Guardian Signature: _____ Date: _____

Central Massachusetts Collaborative

Pick Up and Contact Information Form

Student Name: _____

It is important for all parents and guardians to be aware, that in the event of an emergency, there may be times when their student may need to be picked up from school (e.g., for illness, suspension, student in crisis, student unwilling or unable to safely take the bus home, etc.). If the parent or guardian is unable to come to the school, they must have an emergency contact available to pick up their student. The parent or the emergency contact must pick up their student within **45 minutes** of the initial phone call to notify them.

Parents are also responsible for immediately notifying the school of any phone number changes. Please make sure that your emergency contact information is also kept updated.

By signing below, I acknowledge that:

- I have read the above and understand that I am responsible for picking up my student if asked to do so by the school staff.
- I agree to keep all contact information updated.

Parent/Guardian Signature: _____ Date: _____

Bus Permission Form

THIS FORM IS FOR MIDDLE AND HIGH SCHOOL STUDENTS ONLY

Most bus companies require that a parent or guardian be present when the student is dropped off at home. You may give permission to the transportation company for your student to be dropped off at home without your presence. Please indicate the appropriate option below.

Student's Name: _____

- I give my student permission to be dropped off at home without supervision.
- I **do not** give my student permission to be dropped off at home without supervision. In the instance that I am not present, I understand that he or she will be taken to Quinsigamond Elementary School, where I can arrange for him or her to be picked up.

Parent/Guardian Signature: _____ Date: _____

Central Massachusetts Collaborative

Field Trip Consent Form

The Central Massachusetts Collaborative occasionally arranges for students to participate in field trips that serve an educational and / or therapeutic purpose. By signing below, you grant permission for your student to participate in all future field trips.

Student Name: _____

- I consent and give permission for my student to participate in all field trips.
- I **do not** give permission for my student to participate in field trips.

There are times throughout the year that a class may go on field trips and the School Nurse is unable to attend. In this event, the student's teacher will be properly trained to administer the medication. I understand that the designated person will carry the medication, administer, and observe my student taking the medication.

I give permission for these designated people to administer medication on such field trips for the current school year: Yes No

Parent/Guardian Signature: _____ Date: _____

Parental Consent for PG13 and R-Rated Educational Movies

Classrooms at the Central Massachusetts Collaborative may utilize films or film clips. These may include films that carry a PG13 or R-rating.

Student Name: _____

Please indicate which of the following you authorize:

- I consent to my student viewing PG13-rated films that serve an educational purpose.
- I give my student permission to view PG13 rated films and would like to be notified of the film before it is shown.
- I consent to my student viewing R-rated films that serve an educational purpose.
- I give my student permission to view R-rated films and would like to be notified of the film before it is shown.
- I **do not** give my student permission to view any PG13 or R-rated films.

Parent/Guardian Signature: _____ Date: _____

Central Massachusetts Collaborative

Medication Administration Policy

Dear Parents/Guardian:

We would like to inform you of the policies that have been put in place to ensure the health and safety of the children during the school day regarding medication administration.

Our School district requires that the following forms must be on file in your student's health record before we can give any medication (prescribed or over the counter) at school:

1. **Medical Information Form**: Signed consent by the parent or guardian to give the medication (prescribed or over the counter). Please complete the enclosed Medical Information Form and give it to your school nurse, or send it to school with your student to give to the School Nurse.
2. **Medication Order Form**: Signed Medication Order Form completed by your child's doctor (for prescription medications only). Your student's licensed prescriber must either fill out the provided form or give you their own medication order form to give to the School Nurse. This Medication Order Form must be renewed as needed and at the beginning of each academic school year.
3. **Authorization to Release Information Form (Optional)**: Signed consent by the parent or guardian to speak to the doctor's office regarding medication and paperwork that is related to school use only (Authorization to Release Information Form). This is optional for you to fill out but is very helpful for you to have on file with us in the event that you would like the School Nurse to contact the office on your behalf to get information or paperwork. If this is signed, the School Nurse can call the doctor's office for paperwork to be faxed to us regarding physicals, Immunizations, and medication orders.

Scheduled prescription medications and as needed (inhalers, EpiPens) prescription medications should be delivered to the school in a pharmacy or manufacturer-labeled container by you or a responsible adult whom you designate. Please ask your pharmacy to provide a separate bottle for school and home (they are willing to do this if you inform them you need it). No more than a thirty-day (30) supply of the medicine should be delivered to the school at one time.

When your student needs a medication to be given during the school day, please act quickly to follow these policies so we may begin to give the medication as soon as possible. Thank you for your help!

Sincerely,
Your School Nurses

Central Massachusetts Collaborative

Medical Information Form

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____

Address: _____

Parent/Guardian Name (Printed): _____

Home #:(____)_____ Cell #:(____)_____ Work #: (____)_____

INSURANCE INFORMATION

Primary Care Physician: _____ PCP Phone: _____

Type of Medical Insurance: _____ Subscriber Name: _____

MEDICAL HISTORY

Current medications. Please provide dose and time of all medications, including any inhalers:

Current Medications taken at home/times taken:

Current Medications taken at school/times taken:

Diagnosis: _____

Allergies: _____

Requires an EPI-Pen: Yes No

Epi-Pen Required For: _____

Medical Conditions:

Important Medical History:

My student has the following Allergies (please list all allergies: including environmental, food, and medication allergies): _____

Central Massachusetts Collaborative

Medical Information Form (Continued)

Student Name: _____

DOB: _____

I **consent** to have the School Nurse administer the following medications at school. Please list all medications to be given at school, including as needed medications such as inhalers and Epi-Pens:

The following medications may be given to your child, as needed, after the School Nurse evaluates the student's health status. The School Nurse will **NOT** be able to administer these medications without your permission and signature below.

- | | | |
|--------------------------------|------------------------------|-----------------------------|
| Tylenol (Acetaminophen): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ibuprofen (Motrin/Advil): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Benadryl (Diphenhydramine): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tums (Calcium Carbonate): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Throat Lozenges (Cough Drops): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hydrocortisone Cream: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bacitracin Ointment: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

SIGNATURE & RELEASE

Delegation of Epi-Pens: If the school nurse is unavailable, I give permission for trained school personnel to administer epinephrine to my student in an emergency.

Confidentiality Release: I give permission to the school nurse to share information regarding my student's health with appropriate school personnel and emergency personnel as needed.

Emergency Treatment Release: In case of an emergency and I cannot be reached, I authorize the school to arrange transportation to the nearest hospital emergency room for treatment.

Parent/Guardian Signature

Date

Central Massachusetts Collaborative

Medication Order Form

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE

Name of Student: _____ Date of Birth: _____
Address: _____ Grade: _____
Street City State/Zip

PART 2: LICENSED PRESCRIBER TO COMPLETE

Medication: _____ Dosage: _____

Route: By mouth By inhalation Other _____

Frequency: _____ Time(s) of Each Dose: _____

Specific Directions: _____

Possible Side Effects: _____

Date of Order: _____ Discontinuation Date: _____

Relevant Diagnosis(es): _____

Other Medical Conditions: _____

Other Medications Being Taken: _____

Consent for Self Administration (for PRN medications only, and only if the school nurse determines it safe and appropriate): Yes No

Date of Next Scheduled Visit: _____

Licensed Prescriber's Name (Printed) Phone/Fax Number

Street Address City State/Zip

Licensed Prescriber's Signature: _____ Date: _____

Each medication order must be written on a separate order form. Any changes in directions for medications ordered require an updated Medication Order Form.

Central Massachusetts Collaborative

Authorization to Release Information Form

Student Name: _____ Date of Birth: _____

I, _____ (parent/guardian), hereby authorize and request the release and exchange of records or other information on the student indicated on this form to **CENTRAL MASSACHUSETTS COLLABORATIVE (CMC)** from the following agencies/schools:

Phone Number: _____ Fax Number: _____

Please Forward Information To: _____

The information that may be disclosed, obtained and/or exchanged through this authorization includes the following type of information checked below.

FROM OUTSIDE AGENCIES:

- Verbal interactions between CMC and _____
- Electronic communication including but not limited to fax and email between CMC and the above named entity
- Treatment records: Intake/Admission/discharge summary, Emergency Mental Health reports, and additional evaluations
- All mental health records, including clinical records created or received by the sending institution
- Information pertaining to the diagnosis and treatment of substance abuse

FROM SCHOOLS:

- Academic records including: attendance, transcripts, birth certificate, discipline, grades to date, immunization/health records, 504 plan, ELL records, standardized testing (i.e.: MCAS, MAPS, PARRC)
- Psychological or Neuropsychological evaluations
- Academic/Achievement and Itinerant evaluations (i.e.: OT, PT, Speech, LD)
- Individualized Education Plan
- Other specific information: _____

Central Massachusetts Collaborative

Authorization to Release Information Form (Continued)

This authorization expires one year from the date of signature unless otherwise specified.

**Substance abuse information may not be disclosed without written authorization unless such disclosure is otherwise authorized by federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records (42CFR, Part 2)*

I have carefully read the above, had the opportunity to request clarification on items I may not understand, and;

- I consent to the release and exchange of records or other information.
- I **do not** consent to the release and exchange of records or other information.

CONFIRMATION OF CONSENT

I understand that I may refuse to sign this authorization. I further understand that I may revoke this authorization *in writing* at any time except in circumstances where action has already been taken from reliance on the signed authorization before the written revocation is received. *The written revocation request should be sent to your child's school.*

All legal guardians must sign this consent.

Parent/Guardian Signature: _____

Parent/Guardian Signature: _____

Date: _____