Welcome back to school!

Please fill out each form to completion and submit to the front office by Monday August 18th. You can drop off the packet in the red drop box, drop it off in the front office, or scan and email to schooloffice@oursaviorhartland.org. These forms are all required by the State of Michigan or by Our Savior Lutheran School in order for your child/children to attend.

Contents:

- Emergency Card ***(1 per student)***
- Allergy Form ***(1 per student if applicable)***
- Medication Authorization ***(1 per student if applicable)***
- Handbook Agreement signed ***(1 per family)***
- Mission Statement signed ***(1 per family)***
- Immunizations or Waiver ***(1 per student)***
- Acceptable Use Policy signed ***(1 per student)***
- Concussion Awareness signed ***(1 per student)***
- PTL sheet ***(1 per family)***
- Photo Release/Vacation Form ***(1 per family)***
- Family Messenger Form ***(1 per family)***
- MICR Authorization Form ***(1 per student in K, 7th grade or NEW to the school)***
- Health Appraisal ***(1 per student in K, 7th grade or NEW to the school)***
- Band Form ***(1 per student for 6-8th grade)***
- Background check release ***(1 per parent if you want to volunteer)***
- Central Registry Clearance ***(1 per parent if you want to volunteer)***

Our Savior Lutheran School 13667
West Highland Road, Hartland, MI
48353 PH: 248-887-3836

Emergency Card Information

Student: **Grade**:

Allergies/Medical Alerts:

Parent/Guardian 1:
Address:

Phone:

Email:

Parent/Guardian 2:
Address:

Phone:

Email:

Additional authorized persons to pick up & phone numbers:

Emergency Person(s) to Pick up and phone numbers:

Physician:
Dentist:
Hospital:

In the case of an accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician/dentist/orthodontist listed above. If it is impossible to contact the medical professional, I authorize the school to make whatever arrangements seem necessary on behalf of my child.

Signature: **Date:**

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens:

_____ THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG	HEART	THROAT	MOUTH
Shortness of breath, wheezing, repetitive cough	Pale or bluish skin, faintness, weak pulse, dizziness	Tight or hoarse throat, trouble breathing or swallowing	Significant swelling of the tongue or lips

SKIN	GUT	OTHER
Many hives over widespread	Repetitive vomiting, severe diarrhea	Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body, body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE	MOUTH	SKIN	GUT
Itchy or runny nose, sneezing	Itchy mouth	A few hives, mild itch	Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

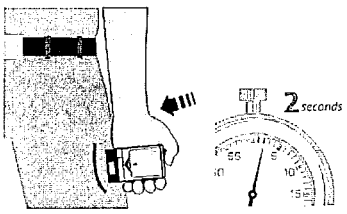
Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q (EPINEPRHINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

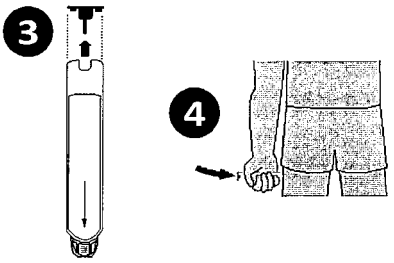


PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

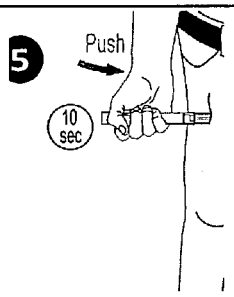
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



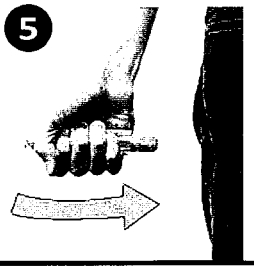
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.): Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickl

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Our Savior Lutheran School
2025-2026 MEDICATION AUTHORIZATION

Authorization for medical interventions to be administered by school personnel:

To be completed by the parent or physician:

Child's Name: _____ Birth Date: _____ Grade: _____

Allergies: _____

Name of Medication	Dose	Form (tablet, liquid, etc.)	Time(s) to be administered

Reason for medication: _____

Special instructions: _____

Start: ☐ date form received other start date: _____

Stop: ☐ end of school year other stop date: _____

Restrictions and/or possible side effects: _____

Special storage requirements: _____

Physician's Name: _____ Phone #.: _____

& Address: _____

I hereby request that Our Savior Lutheran School provide the above ordered medication to my child, _____. I will not hold the school personnel responsible for complications related to this intervention. Any change in the procedure/medication will be accompanied by an updated statement.

_____ _____

Signature of Parent/Guardian Date

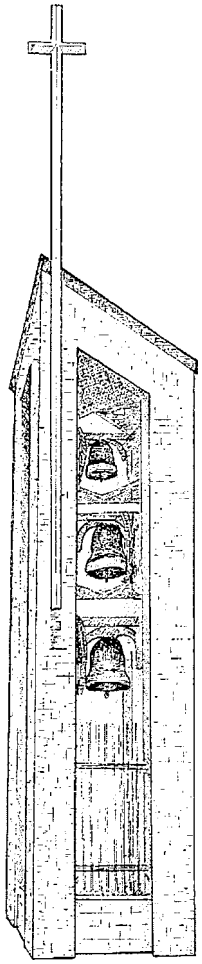
FOR OFFICE USE ONLY

Date form received:

Appendix E

Handbook Agreement for Parents

Our Savior Lutheran School



Parents: Please read the following statements carefully and sign below to indicate your agreement.

I hereby affirm that I have read the School Handbook and discussed its policies with my student.

I certify that I consent to and will submit to all governing policies of the school, including all applicable policies in the School Handbook.

I understand that the standards of the school do not tolerate dishonor to the Holy Trinity and the Word of God, disrespect to the personnel, volunteers, or students of the school, or continued disobedience to the established policies of the school.

I understand that the services of the school are engaged by mutual consent, and that either the school or I reserve the right to terminate services at any time. I understand that this Handbook does not contractually bind Our Savior Evangelical Lutheran Church and School and is subject to change without notice by decision of Our Savior's governing body, the Church Council and its School Board. Admission to the school is a privilege, not a right, and admission for one school year does not guarantee automatic admission for future school years.

_____ _____

Date *Signature of Mother*

_____

Name (Please print)

_____ _____

Signature of Father *Date*

_____

Name (Please print)

****Please return to the school office at Orientation or no later than the first day of school**

Being a member congregation and school of the Lutheran Church-Missouri Synod, the policies and procedures of Our Savior Evangelical Lutheran School are: 1) in full agreement with the doctrinal positions of the LCMS, 2) in full compliance with the doctrinal practices of the LCMS, and thereby 3) of the confession that the Word of God, or the Bible, is the sole norm for faith and practice, being divinely inspired, inerrant, and immutable in meaning. While school policies and procedures are revisited regularly, there may be a lag time between the changing of a church policy and the subsequent aligning of a school policy. In order to maintain faithfulness to Christ and His Word, in all cases the church's policies supersede that of the published school policies.

Our Savior Evangelical Lutheran School
Supporting the Mission Commitment

(Parent copy – Please keep this for your records.)

Our Savior considers its school a primary opportunity for mission. We desire not only to serve our members and community families with an unmatched, high-quality education, but also we earnestly desire to share the most precious gift of the Gospel.

The congregation understands the difficulties and sacrifices that must be made by families in considering a Lutheran education. *Because the Lord Jesus Christ and His saving Gospel are at the core of our identity as a Church and School, the congregation is willing to significantly support the financial realities of the school.* However, the congregation looks to families, both member and community, to be in agreement with and supportive of the mission of the school.

Our Savior does not see the school as a "private Christian school" apart from the congregation, but as a truly parochial, "Lutheran School," which derives its life and energy from Word and Sacrament as lived out in the Divine Service. To help develop understanding of God's saving gifts, students are thoroughly trained in the language, the song, and seasons of the church through the school choirs. Students serve their Lord and the parish through choirs in the Divine Service. To that end, the congregation looks to all school families for several commitments.

Our Savior Member Families

1. At least one parent must be a member of OSELC.
2. The parent(s) and student(s) will be faithful in attendance in the Divine Service.
3. The family will honor the choir/music schedule of their student(s).
4. The family will faithfully support the missional realities of a Lutheran education in proportion to the blessings which the Lord has given them, making this financial commitment a priority.

Community Member Families of Our Savior

1. Maintain faithful attendance in another congregation.
2. The family will honor the Our Savior choir/music schedule of their student(s).
3. The family will actively seek opportunities to serve and support the school, giving freely of their time, talents, and resources in thanksgiving for the quality, Christian education being provided for their children.

Signature(s): _____ Date: _____

_____

(This copy to be returned to the School Office)

Supporting the Mission Commitment
Parents' Statement:

I recognize that Christian education is a blessing and a privilege.
I understand that my family's Christian school is a ministry committed to teaching the truth that Jesus Christ is our Savior.

I want this for my child.

Being aware of the purpose of the Lutheran Grade School, I make a pledge to comply faithfully with the *Supporting the Mission* expectations as presented. I pledge to worship regularly and commit myself and my resources to support Christian Education as a missional effort of Our Savior Evangelical Lutheran Church, Hartland, Michigan.

Signature(s): _____ Date: _____

_____

4.02.2016

Acceptable Use Policy

Student Agreement

I have read, understand, and will abide by the rules stated in the Acceptable Use Policy for Our Savior Evangelical Lutheran School. I understand that computer access is designed for educational purposes and use of computers and the Internet is a privilege, not a right. I understand that any inappropriate behavior or violation of the rules on my part may lead to disciplinary action.

I understand that for my own safety and the safety of my fellow students I will not provide any personal information about myself or others on the Internet, including names, addresses, and/or telephone numbers.

Student Name (please print): _____

Student Signature: _____ Date: _____

(Student must sign at school with teacher)

Parent Agreement

As parent or legal guardian of the student above, I have read, understand, and accept the guidelines outlined in the Our Savior Evangelical Lutheran School Acceptable Use Policy. I grant permission for my son or daughter to have supervised access to the computer network system and the Internet at Our Savior Evangelical Lutheran School. I understand that technology access is designed for educational purposes. I recognize that it is impossible for Our Savior Evangelical Lutheran School to restrict access to all controversial materials, and I will not hold Our Savior Evangelical Lutheran School or any of its personnel responsible for materials acquired on the network. Furthermore, I will support and uphold Our Savior's policies and decisions regarding appropriate usage.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

Some common symptoms

- Headache
- Pressure in the head
- Nausea/ vomiting
- Dizziness
- Balance problems
- Double vision
- Blurry vision
- Sensitivity to light
- Sensitivity to noise
- Sluggishness
- Haziness
- Fogginess
- Grogginess
- Poor concentration
- Memory problems
- Confusion
- "Feeling down"
- Not "feeling right"
- Feeling irritable
- Slow reaction time
- Sleep problems
- Appears dazed and stunned
- Disoriented or confused
- Forgets an instruction

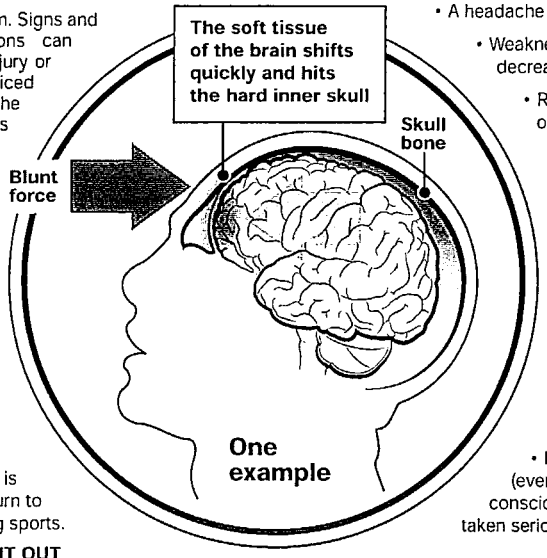
UNDERSTANDING Information for parents and students (Content meets MDCH requirements)

CONCUSSION

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. It can also be caused by the shaking or spinning of the head or body. Even a "ding,""getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

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.



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.

2. KEEP YOUR STUDENT OUT OF PLAY

Concussions take time to heal. Don't let the student return to play the day of the injury and until a health care professional says it's OK. Students who return to play too soon-while the brain is still healing-risk a greater chance of having a second concussion. Repeat or second concussions can be very serious. They can cause permanent brain damage, affecting the student for a lifetime.

3. TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION

Schools should know if a student had a previous concussion. A students school may not know about a concussion received in another sport or activity unless you notify them.

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 or 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.

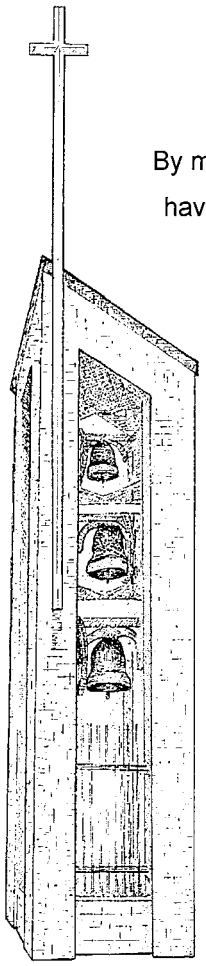
During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

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

!!! WHEN IN DOUBT...SIT OUT !!!

CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT



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 Students provided by Our Savior Lutheran Church and School.

_____	_____
Student name printed	Parent or Guardian name printed
_____	_____
Student signature	Parent or Guardian signature
_____	_____
Date	Date
_____	_____
Student's Date of Birth	Date that student will turn 25 years old

Report any known previous incident(s) of concussion (use back of form if necessary)

_____

_____

Return this signed form to Our Savior Lutheran Church and School. This form will be kept on file for the duration of enrollment/participation and until age 25.

Students and parents should review and keep the educational materials available for future reference

PTL Family Contact Sheet

At multiple times throughout the school year the PTL (Parent Teacher League) will email important information regarding upcoming school activities or events. It is important that we have the information listed below to ensure the correct emails get to the proper families.

Student(s) Name and Grade(s):

_____

_____

_____

_____

_____

First Point of Parent/Guardian Contact Name and Email:

_____

Second Point of Parent/Guardian Contact Name and Email (if two are requested):

_____

With the help of God, we look forward to another fun year of learning and growing our minds and hearts.

Blessings,

Our Savior Lutheran School PTL Board Members

PHOTO RELEASE FORM

I hereby grant to Our Savior Evangelical Lutheran School and its legal representatives and assigns, the irrevocable and unrestricted right to use and publish photographs, videotape, and/or digital images of my child, or in which my child may be included, for editorial, trade, advertising, and any other purpose and in any manner or medium; to alter the same without restriction; and to copyright the same. I further agree that my child's name and identity may be revealed in descriptive text or commentary in connection with the image (s). I hereby release Photographer and their representatives and assigns from all claims and liability relating to said photographs, videotape, and digital images. I, the parent or legal guardian of the person named below, do hereby consent to the foregoing.

Name of student(s): _____

Signature of parent/guardian:_____

Please PRINT the following information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

_____**I DO NOT** give my consent to have photographs of my son/daughter used by Our Savior Lutheran School in any way, as specified above, other than in the school yearbook and class composite photos.

_____**I DO** give my consent to have photographs of my son/daughter used by Our Savior Lutheran School in any way without their name being published, as specified above, other than in the school yearbook and class composite photos. Note: Typical uses of photography are documentation of school activities such as the Fun Run, field trips, spirit week, PTL events, etc. These pictures are often group photos and activity shots and generally used on Sycamore, the PTL page or bulletin board, or otherwise informal ways, with no names published.

VACATION PROCEDURES

When students are absent from school, they miss valuable instructional time that cannot be recreated. Please reference new vacation policy in the School Handbook.

I understand that I must inform the teacher in writing at least one week before a vacation absence. If the absence is longer than three school days in duration, I understand that I must compensate the teacher for any re-teaching that cannot be completed during the school day. I understand that if the scheduled absence exceeds five school days, I must apply to the school board in writing at least one month in advance.

Signature of Parent: _____

Date: _____

Family Messenger 2025-2026

The Flame newsletter will be posted on the Sycamore website each week. Forms needing to be returned to school will continue to be sent home in paper form. Please indicate your child's name below as your family messenger (if you have more than one student enrolled, please list who you would like to have forms sent home with).

Family Messenger's Name: _____Grade: _____

Snow Day / School Cancellations

Messages regarding school cancellations will still be available on media (radio/television), but this year, instead of email, text messages will be used. Please provide the cell phone (s) you would like to receive school cancellation messages.

Name/Cell # _____ Name/Cell # _____

Preferred E-mail Address for Billing

Name: _____ Email Address: _____

Preferred E-mail Address(es) for the PTL

___ Same as above ___ If different: _____

Caregiving Program

The PTL coordinated "Caregiving" program is available to assist Our Savior families in need during the school year.

If you are available to volunteer your assistance, please check the appropriate items below.
(The program can only be successful through "good communication" and plenty of volunteers.)

____ Yes, I will assist with meal preparation for school families.

____ Yes, I will be available to transport children in an emergency situation

____ No, I am not available to assist at this time

Printed Name: _____ Phone Number: _____

MICR Authorization

Our Savior Lutheran School and Early Childhood Center

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 Our Savior Lutheran School and Early Childhood Center 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: ____/____/____

Student's Grade: _____

Printed Parent/Guardian Name: _____

Signature of Parent/Guardian: _____ Date:___/____/___

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

CHILD'S NME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Ye	N	# Is your child having any of the problems listed below?
		1 Allergies or Reactions (for example, food, medication or other)
		2 Hay Fever, Asthma, or Wheezing
		3 Eczema or Frequent Skin Rashes
		4 Convulsions/Seizures
		5 Heart Trouble
		6 Diabetes
		7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
		8 Trouble with Passing Urine or Bowel Movements
		9 Shortness of Breath
		10 Speech Problems
		11 Menstrual Problems
		12 Dental Problems: Date of Last Exam / /
		Other (please describe):
		Does your child take any medication(s) regularly?
		Reason for Medication

Birth History:

Are there any current or past diagnosis(es) Yes No

If yes, please describe:

If yes, list medications:

/ /

Parent/Guardian Signature Date

Was the health history reviewed by a health professional? Yes No ***Examiner's Initials:***

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

N	Ye	Was child tested for:	Test results:	Normal	Referred	Under Ca
		VISION	Visual Acuity			
			Muscle Imbalance			

N	Ye	Was child tested for:	Test results:	Normal	Referred	Under Ca
		HEIGHT & WEIGHT	Height			
			Weight			

Date: /	Other:		h h	Other:	Other
HEARING	Audiometer		h h	HEMOGLOBIN / HEMATOCRIT ⇨	
Date: /	Other:		h h	BLOOD PRESSURE	Reading:
h h /	Sugar			TUBERCULIN	Type:
URINALYSIS	Albumin				
Date: /	Microscopic			Date: / /	
h h /			h h		Neg.: h Pos.: h mm
BLOOD LEAD LEVEL	Level ug/dl ⇨		**NOTE:** Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.		
h h Date: / /					

Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV4/HPV2)	1	3
	2	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

History of Chickenpox Disease? h Yes h No If yes, date:

Parent/Guardan refused immunizations: h

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.

I certify that the immunization dates are true to the best of my knowledge

Health Professional's Signature	Title	/ / Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
h	h	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
h	h	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): h Classroom h Playground h Gymnasium h Swimming Pool h Competitive Sports h Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined 's teeth. As a result of this examination, my recommendation for treatment is: child's name

Dentist's Signature Date

PHYSICIAN'S SIGNATURE

Examiner's Signature Date *Examiner's Name (Print or Type)* Degree or License

MI

/ /

Number & Street City ZIP Code ( ) Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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Developed in Cooperation with the Departments of Human Services, Education, Community Health, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

Band

Time to Make Music!

5th GRADE

Beginning band will be offered 2 days per week and is **required** for all 5th grade students.

During the first few weeks, students will be introduced to the instruments on which instruction will be offered:

flute, clarinet, alto sax, trumpet, trombone.

Each student will have the opportunity to "try out" the instrument(s) of their choosing.

When every student has been carefully "fitted" for an instrument, information on instrument rental will be shared with parents. Purchasing an instrument is not recommended this early in the instruction process.

6th, 7th AND 8th GRADE

Band is optional for 6th–8th grade students. Please check here if your student plans to have Band or Study Hall.

_____Band or _____ Art Appreciation

Name _____ Grade_____

The Band instructor will be working with Meyer Music. Instruments can be rented online and delivered directly to the school, including the method book and folding music stand. Current rental fees are as follows (credited toward purchase, if purchase is later desired):

- Flute, Clarinet, Trumpet, Trombone - approximately $34/month
- Alto Saxophone - approximately $68/month (7th/8th grade only) --those interested in saxophone will start on clarinet for first semester No percussion instruction will be offered first semester.

Any other instruments need to be inspected/evaluated by Mr. Hartman prior to use to assure the best possible outcome for the student. If you have an instrument to be evaluated, whether for your student, or to lend or donate to the school for another student who may have financial need, please drop off at the school office.

OUR SAVIOR LUTHERAN EVANGELICAL CHURCH AND SCHOOL

13667 West Highland Road, Hartland, Michigan 48353
Phone (248) 887-4300 www.oursaviorhartland.org Fax (248) 887-3596
The Lutheran Church – Missouri Synod

PUBLIC ACT 99 OF 1993 & PUBLIC ACT 83 OF 1995

AUTHORIZATION FOR CRIMINAL RECORDS CHECK RELEASE OF INFORMATION TO LOCAL DISTRICT

The undersigned is a parent chaperone/volunteer with Our Savior Evangelical Lutheran Church & School and has given church administrators permission to request and receive a criminal records check through the Michigan State Police

READ CAREFULLY – THIS DOCUMENT CONTAINS A RELEASE

Print Name _____ Male _____ Female _____
(Last, First, Middle)

Address _____ _____ _____ _____
(Street Address) (State) (Zip Code) (Phone Number)

Birthdate: _____ Race: _____
(Month/Day/Year)

I do hereby release Our Savior Evangelical Lutheran Church and School, its individual board members, employees, and agents, past and present, from any and all claims and/or liability whatsoever for any damages or consequences which may result from the criminal records check related to my position as a volunteer candidate with Our Savior Lutheran Church and School.

Dated _____

_____
Print Full Name

_____
Signature

"We preach Christ crucified..." 1 Corinthians 1:23

DHS-1929, CENTRAL REGISTRY CLEARANCE REQUEST

Michigan Department of Health and Human Services
(Revised 11-22a)

COPY PHOTO ID HERE

OR

ATTACH A SEPARATE PAGE

SECTION 1 – INFORMATION ON PERSON BEING CLEARED

Name, (First, Middle, Last)	Signature Required for Individual Being Cleared	Date

Maiden Name, Aliases, also known as (A.K.A)	Social Security Number	Date of Birth

Address	City	State	Zip Code

Phone Number	Email

☐ I am completing this for myself.
☐ I would like to pick up my results in County (For Michigan Residents Only).

SECTION 2 – REQUESTER INFORMATION

Check Appropriate Box
☐ Employer
☒ Volunteer Agency
☐ Adoption/Foster Care Home Screening
☐ Court/Law Enforcement/Department of Corrections/Prosecuting Attorney
☐ Child Caring Institution
☐ Other

Name of Agency or Organization	Name of Requester
Our Savior Evangelical Lutheran Church	Nicole Spangler

Address	City	State	Zip Code
13667 Highland Road	Hartland	MI	48353

Email	Fax	Phone Number
nspangler@oursaviorhartland.org	248-887-3596	248-887-4300

Effective November 1, 2022, only confirmed cases of methamphetamine production, confirmed serious abuse or neglect, confirmed sexual abuse, or confirmed sexual exploitation will be classified as a central registry case in Michigan. Individuals may have child welfare history that previously resulted in central

registry placement, but that would no longer meet the criteria. In addition, select criminal convictions involving children will result in placement on central registry.

This clearance does not identify individuals with child abuse/neglect history who did not meet the new central registry requirements as noted above or history in other states, territories, or tribal trust land.

With your signature, you are authorizing agencies to receive notice of all placements on central registry as allowable by Child Protection Law (MCL 722.627-722.627j).

The confidentiality of central registry information is protected by Sections 7 through 7j of the Michigan Child Protection Law (MCL 722.627-722.627j). Anyone who violates this protection is guilty of a misdemeanor and is civilly liable for damages.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.