Dear Parent/Guardian:

We are pleased you have chosen to educate your child in The Euclid City School District. Attached is the Career Tech registration packet that needs to be completely filled out and signed by you. Only parents, legal guardians, and legal custodians may register children for this program.

The deadline to return the packet is _______________________. Please return it to:

The Euclid High School
Career Tech Program
711 East 222 Street
Euclid, OH 44123

If you have any questions, please contact me at the Euclid High School at 216-797-7834.

Sincerely,

Kathleen Gonakis
Career Tech/College Now Coordinator
Please PRINT clearly with blue or black ink only.

<table>
<thead>
<tr>
<th>Home District High School:</th>
<th>Entry Grade:</th>
<th>Educational Needs: Does your child have a(n)</th>
<th>IEP/IFR? Yes □ No □</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>504? Yes □ No □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student's Name:</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Birth Date: (mm/dd/yyyy)</th>
<th>Birth Place:</th>
<th>City</th>
<th>State or Country</th>
<th>Gender: Male □ Female □</th>
</tr>
</thead>
</table>

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<thead>
<tr>
<th>Race/Ethnicity: (Check all that apply.)</th>
<th>Native Language:</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American/Black □</td>
<td>English □</td>
</tr>
<tr>
<td>American Indian/Alaskan Native □</td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander □</td>
<td>Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Street Address:</th>
<th>House Number</th>
<th>Street</th>
<th>Apt. #</th>
<th>City</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Student lives with the following at the same address:

1. Last Name ___________________________ First Name ___________________________
   Relationship: Mother □ Father □ Grandparent (has POA) □ Foster Parent □
   Marital Status: Single □ Married □ Divorced □ Separated □ Widow/Widower □
   Primary Phone Number ___________________________ Email Address: ___________________________

2. Last Name ___________________________ First Name ___________________________
   Relationship: Mother □ Father □ Grandparent (has POA) □ Foster Parent □
   Marital Status: Single □ Married □ Divorced □ Separated □ Widow/Widower □
   Primary Phone Number ___________________________ Email Address: ___________________________

If applicable, non-custodial contact information (does not live with the student):

Mother □ Father □ Caseworker □ Agency: ___________________________

Last Name ___________________________ First Name ___________________________

Street Address: House Number: _______ Street: _______ Apt. #: _______ City: _______ State: _______ Zip Code: _______

Primary Phone Number ___________________________ Email Address: ___________________________

Parent's/Guardian's Signature: ___________________________ Date: ___________________________
**Student Health Information Form**

**Student Name** ___________________________  **Date of Birth** ____________  **Grade** ____

**Physician’s Name** ___________________________  **Phone#** ________________

**Dentist’s Name** ___________________________  **Phone#** ________________

Please check all the following that the student currently has or has had in the past:

- [ ] Allergies – List all
  - Food  Reaction  Recommended Treatment
  - Insect Stings  Reaction  Recommended Treatment
  - Plants/Animals  Reaction  Recommended Treatment
  - Medications  Reaction  Recommended Treatment

- [ ] Asthma:  Medication ___________________________

- [ ] Attention Deficit Hyperactivity Disorder (ADHD/ADD):  Medication ___________________________

- [ ] Chicken Pox Disease:  Date ____________  Type ___________________________

- [ ] Convulsions/Seizures:  Frequency ____________  Age of last seizure ____________  Type ___________________________

- [ ] Diabetes:  Age of Onset ____________  Treatment ___________________________

- [ ] Ear Infections:  Frequency ____________  Age of last infection ____________  Tubes ___________________________

- [ ] Hearing Problems:  Describe ___________________________

- [ ] Heart Disease:  Describe ___________________________

- [ ] Kidney Disease:  Describe ___________________________

- [ ] Migraines:  Treatment ___________________________

- [ ] Rheumatic Fever:  Date ____________

- [ ] Sickle Cell Anemia:  Date/Describe ___________________________

- [ ] Skin Disorder:  Describe ___________________________

- [ ] Speech Problems:  Describe ___________________________

- [ ] Stomach/Intestinal Disorders:  Describe ___________________________

- [ ] Strep Infections:  Frequency ____________  Date of last infection ____________

- [ ] Tuberculosis:  Date/Describe ___________________________

- [ ] Vision Problems:  Describe ___________________________

- [ ] Other Physical Disabilities:  Describe ___________________________

Please answer the following questions:

1. Does your child take any medications daily? Specify ___________________________
    What medications are given frequently, but not daily  □ Yes  □ No

2. Does your child have any emotional/behavioral health concerns?
    Describe ___________________________  □ Yes  □ No

3. Has your child ever had any operations or serious illness?
    Explain ___________________________  □ Yes  □ No

4. Has your child had any serious accidents?
    Explain ___________________________  □ Yes  □ No

5. Does your child wear eyeglasses, contacts, braces, or any other corrective devices?
    Describe ___________________________  □ Yes  □ No

6. Is your child able to participate fully in a physical education program?
    ___________________________  □ Yes  □ No

**Parent/Guardian’s Name (Please Print)** ___________________________

**Parent/Guardian’s Signature** ___________________________  **Date** ____________

Revised 02/2014
In compliance with Ohio Law mandating strict policy and procedures regarding the administration of medication in the school setting, the Euclid Board of Education requires adherence to the following:

1. If possible, all medication should be given by the parent at home. If this is not possible, parents may come to school to administer medication to their child. **School personnel will be permitted to administer medications only when no alternative is available.** For the purpose of this policy, the term medication is defined as any prescription or non-prescription/over-the-counter medicine.

2. The board approved **Daily Medication Log/Parent Consent and Physician Order form must** be on file in the school clinic. The form complies with Ohio Revised Code 3313.73. All sections of the form must be completed.

3. Parent/guardian will provide a revised form if there is any change in information.

4. Medication shall be received by the school in the container in which it was dispensed by the pharmacy. It must have a label affixed which includes:
   - Student’s name
   - Name of medication
   - Dosage
   - Frequency of administration
   - Name and telephone number of pharmacy

5. Parent/guardian is required to transport medication to and from school.

6. A new **Parent Consent and Physician Order Form** must be provided each school year.

7. A parent/legal guardian will be contacted by the school’s health monitor if there are any questions about the type of medication, its administration, or possible side effects. At no time will medication be administered or taken at school when there are unanswered questions.

The Administration of Medication form is available in the school clinic.
Purpose 1) To enable parents and guardians to provide information and to authorize the provision of emergency treatment for a student who becomes ill or is injured while under school authority, and 2) to provide necessary information needed for school personnel to care for a student in the event of sheltering during a disaster.

School ___________________________ Grade ______ Teacher ___________________________

Student Name ___________________________________________ Last Name ____________
 First Name __________ Middle ______ Date of Birth __________

Home Address ___________________________________________ Apt. __________ City __________ Zip __________
Home Phone (_____) __________________________ Family E-Mail __________

**Parent(s) or Guardian with Whom Student Lives**

<table>
<thead>
<tr>
<th>Name/Relationship to Student</th>
<th>Name/Relationship to Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell (<em><strong><strong>) Daytime Phone (</strong></strong></em>)</td>
<td>Cell (<em><strong><strong>) Daytime Phone (</strong></strong></em>)</td>
</tr>
</tbody>
</table>

**Non-Residential Parent**

<table>
<thead>
<tr>
<th>Name/Relationship to Student</th>
<th>Home Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address _______________________ Apt. __________ City __________ State __________ Zip __________</td>
<td></td>
</tr>
<tr>
<td>Cell (<em><strong><strong>) Daytime Phone (</strong></strong></em>)</td>
<td></td>
</tr>
</tbody>
</table>

Is there a court order which limits/prohibits non-custodial parent contact?  YES  NO
If YES is circled, parent must contact Registration at board office and provide legal documentation.

*List the person(s) who will care for your child in case of emergency or if parent cannot be reached. List contacts in the order in which you prefer them to be called. Please note that your children will also be released to this person(s).*

1. ___________________________ (_____) Phone
   Name/Relationship to Student

2. ___________________________ (_____) Phone
   Name/Relationship to Student

3. ___________________________ (_____) Phone
   Name/Relationship to Student

*Additions or deletions of emergency contacts must be made in writing and submitted to your school's health monitor.*

Please include the name of an older sibling who is authorized to pick up student in the event of a disaster.

______________________________ ___________________________
Name/Relationship to Student Name of School & Grade Level

**EMERGENCY MEDICAL INFORMATION AND AUTHORIZATION ON NEXT PAGE MUST BE COMPLETED.**
INFORMATION CONCERNING STUDENT’S HEALTH
(Please Print)

Medical History: ____________________________________________________________

Allergies (insect, food, medication, etc.): __________________________________

Medications taken (including dosage and times given): __________________________

Describe any critical medical information the bus driver should be aware of when transporting this student:

________________________________________________________________________

Please Note: If your child would need to take any medication during a 24-hour period of “sheltering in place”
Please contact your school’s health monitor or the district nurse to discuss this matter confidentially.

CHECK PART ONE OR PART TWO AND SIGN BELOW:
In the event that reasonable attempts to contact me (or the persons listed on this form) have been unsuccessful:

PART ONE: TO GRANT CONSENT

☐ I grant consent. I hereby give my consent for
1) The administration of any treatment deemed necessary by:

Dr. ___________________________________ Address __________________ Phone _________
(preferred physician)

Dr. ___________________________________ Address __________________ Phone _________
(preferred dentist)

Or in the event the designated practitioner is not available, by another licensed physician or dentist.

2) The transfer of the child to (preferred hospital) ________________________________, or any hospital
reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or
dentists, concurring in the necessity for such surgery, are obtained prior to the performance of the surgery.

Signature of Parent ___________________________ Date ______

PART TWO: REFUSAL TO GRANT CONSENT

☐ I refuse to grant consent. I do not give consent for emergency medical treatment for my child. In the event of illness or injury
requiring emergency treatment, I wish the school authorities to take no action or to:

________________________________________________________________________

Signature of Parent or Guardian ___________________________ Date ______

I UNDERSTAND THAT I AM RESPONSIBLE FOR KEEPING ALL INFORMATION CURRENT AND CORRECT.
All changes to this form must be submitted in writing to the school’s health monitor and signed by parent or guardian.