



Registration Instructions

Complete the registration packet prior to submission.

Enrollment is by appointment only. Exception: NO appointment is necessary during the spring kindergarten enrollment event.

Submit all completed forms and documents listed below that are **required by the Board of Education** at the time of your enrollment appointment.

- Completed registration packet – one for each student
- Student birth certificate, Visa or passport
- Parent/Guardian identification –driver's license or state ID
- Custody papers - most recent (if applicable)
- Current immunization records (kindergarten)
- Copy of IEP or 504 (if child has special needs)
- Proofs of residency – provide 2 of the following:

Real estate documents, tax bill, lease agreement (**required if renting or leasing**), current utility bill, bank statement, or voter registration with address.

Persons renting with residents: Owner must complete the Residency Affidavit and provide two proofs of residency; tenant must complete residency affidavit and provide one proof.

Please Note: Only a custodial parent/legal guardian can officially enroll a student, therefore they MUST be the person present at the registration appointment.

ALL DOCUMENTS MUST BE RETURNED TO:

Secretary of Pupil Services

6638 Mill Rd. Brecksville, Ohio 44141 Phone 440-740-4027

Brecksville-Broadview Heights City Schools

Important!! Read before completing this form.

The laws of the State of Ohio (Revised Code Section 3313.64, 3313.08, 3327.06) provide that a school age child under the age of 18 years can attend school only in the district in which his/her parent(s) or other court appointed guardian have established legal residence.

Children found to be attending school in defiance of the residency conditions set forth are to be removed from the school district and not to be permitted to continue to attend in that district. The district reserves the right to charge tuition for student attendance in violation of the residency agreement.

Registration Date _____ Anticipated Start Date _____

Has the student been enrolled in the Brecksville-Broadview Heights District previously? Yes ___ No ___

If yes, when? _____

STUDENT INFORMATION

Legal Birth Name of Student Date of Birth Gender Grade

Student Lives With: Both Parents (same residence) Both parents (two residences-shared custody)

Biological Mother Biological Father Relative/Guardian Court Placement Other

RESIDENTIAL PARENT/GUARDIAN INFORMATION

Mother Father Guardian Other Mother Father Guardian Other

Name

Name

Address

Address

Home Phone

Home Phone

Cell Phone

Cell Phone

Work Phone

Work Phone

E-Mail Address

E-Mail Address

Residency Affidavit

For the purpose of establishing school residence
To be completed by Parent/Guardian or Resident and NOTARIZED

Name of Resident: _____ I certify that I am Owner Tenant
 Resident of the dwelling/apartment located as denoted below. I am a **FULL TIME** resident within the Brecksville-Broadview Heights City School District, and I **DO NOT** maintain a separate resident elsewhere.

RESIDENCE: _____
Street Address
City
Zip
Date of Occupancy

CERTIFICATION By initialing the following statements, I certify that:
 _____ This information is true, accurate and not made for the purpose of circumventing the attendance laws of the State of Ohio or the policies of the Board of Education requiring the legal residency in order to attend the Brecksville-Broadview Heights Schools.
 _____ If I change my present address to another address that is within BBHCSD, I will **IMMEDIATELY** notify my child(ren's) school and provide required residency documents as noted below.
 _____ I understand and agree that if the above address ceases to be my legal residence and my new residence is outside the boundaries of BBHCSD, I will withdraw my child(ren) from BBHCSD. I further understand that I will be responsible for, and pay the current full tuition rate to the Treasurer of BBHCSD, pursuant to Section 3317.08 of the O.R.C. for the part of the school year that my child(ren) were illegally enrolled in BBHCSD.

RESIDENCE VERIFICATION Present verifications to the Enrollment Registrar at the time of enrollment for copying

Owner of Dwelling: any two (2) of the following **original** items are acceptable:

- | | | |
|--------------------|---|------------------------|
| Driver's License | Purchase/Construction Contract | Deed |
| Voter Registration | Paycheck Stub | Property Tax Statement |
| Insurance Policy | Utility Bill | Home Mortgage |
| Lease Agreement | Other Reliable Documentation (Board Approved) | |

TENANT of the dwelling: Current signed lease agreement and one (1) verification from above list

Parent/Guardian residing with BBHCSD resident: the owner or tenant of residence must provide two (2) verifications as required including a lease. The parent/guardian registering and residing with the resident must complete separate Residency Affidavit and provide one (1) verification from above list.

Persons in the Home List the names of persons, both adult and children who reside at the above address

Name	DOB	Name	DOB
_____	_____	_____	_____
_____	_____	_____	_____

Students Name _____ DOB _____ Grade _____

SIGN ONLY IN THE PRESENCE OF A NOTARY PUBLIC

 Parent/Guardian or Resident Relationship to Student Date _____

Sworn to and subscribed before me this _____ day of _____ 20____

(Affix Seal) _____

CUSTODY PENDING FORMS

Student	DOB	Parent/Guardian	Relationship
Residence _____			

Indicate (if applicable): either Part I Custody or Part II: Custody Pending

Check if applies

Part I: Custody – Current Court Orders *establishing Custody or Guardianship* (attachment)

I certify that I am the parent/ legal custodian of student and have established permanent residency in the Brecksville-Broadview Heights City School District.

I have provided the school officials with a **signed, certified copy** of the court order granting legal custody. I also certify that this is the MOST RECENT and there have not been any custodial changes.

[Section 3313.672 O.R.C. REQUIRES A CUSTODIAL PARENT TO PROVIDE THE PUBLIC SCHOOL WITH A CERTIFIED COPY OF THE CUSTODY ORDER. ANY CHANGES OR MODIFICATION IN THE CUSTODY ORDER MUST ALSO BE SUBMITTED TO THE SCHOOL WHEN THEY OCCUR.]

REQUIRED: ATTACH SIGNED, CERTIFIED COPY OF COURT ORDER

Check if applies

Part II: Custody Pending – Filed APPLICATION of Appointment for Custody of Minor (attachment)

I have reached the age of majority, residing in the Brecksville-Broadview Heights City School District have filed an Application for the Appointment of Custody of a Minor, with the Probate Court of Cuyahoga County, Ohio. A certified copy of the filed application with the court docket is attached hereto as Exhibit A (Required Documentation)

I understand that Ohio Law (93313.64) allows Brecksville-Broadview School District to enroll this child for up to sixty (60) calendar days, tuition free, with a copy of the legal documentation that custody proceedings have been started.

If I have NOT been given legal custody by the **sixty calendar day timeline**, I agree to pay the Brecksville-Broadview Heights School District the current tuition rate per day as calculated by the Ohio Department of Education, Division of School Finance. Hence, I will provide the school within **sixty days** a copy of the signed court order granting legal custody.

I understand that the above named child will be removed from Brecksville-Broadview Heights City School District if the *timeline* is not met, and will be required to attend the school system of his/her legal custodian.

REQUIRED: ATTACH SIGNED, CERTIFIED COPY OF FILED APPLICATION WITH COURT DOCKET

Part III: Sign and Notarize – Sign ONLY in the presence of a Notary Public

I have read this entire document and the information provided by me on this form is true and accurate.

Signature (Parent or Guardian)

Date

Sworn to and subscribed before me on this ____ day of _____, 20____.

Notary Public

(Affix Seal)

**** This document must be attested to and signed before a Notary Public before submission to Brecksville-Broadview School District**

Neola 5111 F2b

ATTACH COPY OF DOCUMENT

Brecksville-Broadview Heights City School District

AUTHORIZATION FOR RELEASE AND/OR INFORMATION FROM RECORDS

NOTE: When submitted, this authorization will become part of the student's permanent record in accordance with the Family Rights and Privacy Act of 1974 and Board of Education Policy

Student Name _____

Student Birthdate: _____ Grade _____

Previous School District and School _____

Previous School Address _____

Previous School Phone _____ Fax Number _____

The School/Agency is authorized to release the records below:

Academic Grades

Attendance data

Group administered achievement and/or aptitude test scores (i.e. Ohio State Assessment/OGT, Stanford, Terra Nova, I.E.P., MFE, 504, ELL, if applicable

Psychological reports

Speech/Language and/or Hearing/Vision evaluation

Limited English Proficiency Scores (OELPA), if applicable

SAT, ACT, PSAT, Plan Results

SSID# (Please send this number on a Post-It Note attached to the first page)

The records indicated above are to be released to:

- Chippewa Elementary 8611 Wiese Road Ph 440-740-4200 Fax: 440-740-4204
- Highland Elementary 9457 Highland Dr. Ph 440-740-4300 Fax: 440-740-4304
- Hilton Elementary/Presch 6812 Mill Road Ph 440-740-4600 Fax: 440-740-4604
- Central School 27 Public Square Ph 440-740-4100 Fax: 440-740-4104
- BBH Middle School 6376 Mill Road Ph 440-740-4400 Fax: 440-740-4454
- BBH High School 6380 Mill Road Ph 440-740-4700 Fax: 440-740-4732

Reason for Request: (please check) _____ To aid in present/future education _____ Other

I hereby grant permission for release of information between the two parties.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Entrance Physical Exam - Required for Preschool, KG & 1st Grade students. To be completed by Physician.

Student Name _____ DOB: ____/____/____ Grade _____

IMMUNIZATIONS Complete using entire date as follows: mm/dd/yyyy

DTP, DT or DTaP	1 _____	2 _____	3 _____	4 _____	5 _____
Td or Tdap	1 _____	2 _____	3 _____	4 _____	5 _____
Polio IPV/OPV	1 _____	2 _____	3 _____	4 _____	5 _____
HIB	1 _____	2 _____	3 _____	4 _____	5 _____
Hepatitis B	1 _____	2 _____	3 _____		
MMR	1 _____	2 _____			
Varicella (vaccine)	1 _____	2 _____			
Meningococcal	1 _____	2 _____			
Other _____					

Immunization Exemption: When statement required from parent/guardian or physician. (ORC Section 3313.671)

EXAM Date ____/____/____ Height _____ Weight _____ BP _____

Findings All Normal or Indicate any **abnormal findings below:**

Remarks/Recommendations

- | | |
|---|--|
| <input type="checkbox"/> Posture _____ | <input type="checkbox"/> Heart _____ |
| <input type="checkbox"/> Neck _____ | <input type="checkbox"/> Lungs _____ |
| <input type="checkbox"/> Skin _____ | <input type="checkbox"/> Abdomen _____ |
| <input type="checkbox"/> Nervous system _____ | <input type="checkbox"/> Genitalia _____ |
| <input type="checkbox"/> Hernia _____ | |

Restrictions: _____

Hearing: Test Type: _____ Results _____ Comments _____

Vision: Acuity: Right-20/____ Left-20/____ Strabismus: yes no Comments _____

Dental: General dental health: _____ Work indicated: yes no

Chronic Health Concerns: Asthma Seizures ADD/ADHD Diabetes Other _____

Comments: _____

<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____

Indicate if child was referred to a specialist for any reason (explain): _____

Special Tests-(physicians' discretion): Urinalysis _____ Hematocrit _____ Lead _____

Sickle Cell _____ TB Test _____ Date: ____/____/____ Results: Positive Negative

Physician Information: (print/type/stamp)

Name _____
 Address _____
 City/State/Zip _____
 Phone(____) _____

Based on examination consistent with
 EPSDT/Headstart/AAP Guidelines, I certify
 this child to be in suitable condition for
 enrollment in school.

Physician Signature _____

Date ____/____/____

ETHNIC AND RACIAL DATA FORM / NATIVE LANGUAGE AND HOME LANGUAGE DATA FORM

Brecksville-Broadview Heights City Schools is the Provider/Sponsoring Agency and receives federal financial assistance for participating in the Child and Adult Care Food Program (CACFP). Because they receive federal financial assistance, they are required to record and maintain the Ethnic and Racial Data of all children enrolled in the district. This information is used solely for the purpose of determining compliance with Civil Rights Laws and will be kept confidential. We are requesting each of our participants to 'Self-Identify' and provide this information, however it is optional to Self-Identify. If you choose not to Self-Identify, please be aware that the Provider/Sponsoring Agency will need to make a judgment of your child's race and ethnicity because Civil Rights Laws require them to do so. This ethnic and racial information will remain confidential and on file for 3 years and will only be accessible to authorized personnel.

Child's Name: _____

Check One: Ethnic Category

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic" or "Latino".	
Non-Hispanic or Latino:	

Check ALL That Apply: Racial Categories

American Indian or Alaska Native: Persons having origins in any of the original peoples of North and South America, (including Central America) and who maintain tribal affiliation or community attachment.	
Asian: Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
Black or African American: Persons having origins in any of the black racial groups in Africa.	
Native Hawaiian or Other Pacific Islander: Persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
White: People who have origins in any of the original peoples of Europe, North Africa, or the Middle East.	

Parent/Guardian Signature: _____ Date: _____

PLEASE COMPLETE BOTH SIDES OF FORM

Year the student entered school in the United States: _____

Year the student entered a school in the State of Ohio: _____

Native Language: Check At Least One in This Box

"Native" or first language of the student is often the language spoken at home but should denote the primary language spoken by the student at the onset of speech.

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> ENG English | <input type="checkbox"/> ALB Albanian | <input type="checkbox"/> AMH Amharic | <input type="checkbox"/> ARA Arabic |
| <input type="checkbox"/> CAM Cambodian | <input type="checkbox"/> CAN Cantonese | <input type="checkbox"/> CRE Creole (French) | <input type="checkbox"/> GER German |
| <input type="checkbox"/> HMG Hmong | <input type="checkbox"/> JPN Japanese | <input type="checkbox"/> KOR Korean | <input type="checkbox"/> LAO Laotian |
| <input type="checkbox"/> NAV Navajo | <input type="checkbox"/> PTG Portuguese | <input type="checkbox"/> ROM Romanian | <input type="checkbox"/> RUS Russian |
| <input type="checkbox"/> SBC Serbo Croat | <input type="checkbox"/> SOM Somali | <input type="checkbox"/> SPN Spanish | <input type="checkbox"/> TAG Tagalog |
| <input type="checkbox"/> TRI Tigrinya | <input type="checkbox"/> UKR Ukrainian | <input type="checkbox"/> VTM Vietnamese | <input type="checkbox"/> OTH Other |

Home Language: Check at Least One in This Box

Home Language is the main language spoken at home by the student.

- | | | |
|---|---|---|
| <input type="checkbox"/> QOT Language not included in option list | <input type="checkbox"/> AKA Akan | <input type="checkbox"/> ENG English |
| <input type="checkbox"/> AMH Amharic | <input type="checkbox"/> ARA Arabic | <input type="checkbox"/> BAM Bambara |
| <input type="checkbox"/> BAS Basaa | <input type="checkbox"/> BEN Bengali | <input type="checkbox"/> BUL Bulgarian |
| <input type="checkbox"/> MYA Burmese | <input type="checkbox"/> KHM Cent Khmer | <input type="checkbox"/> LOU Louisiana CreoleFrench |
| <input type="checkbox"/> HRV Croatian | <input type="checkbox"/> DAN Danish | <input type="checkbox"/> SQI Albanian |
| <input type="checkbox"/> EWE Ewe | <input type="checkbox"/> FIL Filipino | <input type="checkbox"/> FUL Fulah |
| <input type="checkbox"/> KAT Georgian | <input type="checkbox"/> DEU German | <input type="checkbox"/> GUJ Gujarati |
| <input type="checkbox"/> HEB Hebrew | <input type="checkbox"/> HIN Hindi | <input type="checkbox"/> HUN Hungarian |
| <input type="checkbox"/> IBO Igbo | <input type="checkbox"/> IND Indonesian | <input type="checkbox"/> JPN Japanese |
| <input type="checkbox"/> KSW Karen | <input type="checkbox"/> KIK Kikuyu | <input type="checkbox"/> KOR Korean |
| <input type="checkbox"/> KQO Krahn | <input type="checkbox"/> KRI Krio | <input type="checkbox"/> LAO Lao |
| <input type="checkbox"/> LIT Lithuanian | <input type="checkbox"/> YMM Maay | <input type="checkbox"/> MSA Malay |
| <input type="checkbox"/> MAL Malayalam | <input type="checkbox"/> MAN Mandingo | <input type="checkbox"/> MON Mongolian |
| <input type="checkbox"/> NAV Navajo | <input type="checkbox"/> NYA Nyanja | <input type="checkbox"/> PAN Panjabi |
| <input type="checkbox"/> FAS Persian | <input type="checkbox"/> POL Polish | <input type="checkbox"/> PUS Pushto |
| <input type="checkbox"/> RON Romanian | <input type="checkbox"/> RUS Russian | <input type="checkbox"/> SNA Shona |
| <input type="checkbox"/> SIN Sinhala | <input type="checkbox"/> SOM Somali | <input type="checkbox"/> SWH Swahili |
| <input type="checkbox"/> SWE Swedish | <input type="checkbox"/> TGL Tagalog | <input type="checkbox"/> TEL Telugu |
| <input type="checkbox"/> THA Thai | <input type="checkbox"/> TIR Tigrinya | <input type="checkbox"/> TUR Turkish |
| <input type="checkbox"/> TWI Twi | <input type="checkbox"/> UKR Ukrainian | <input type="checkbox"/> UZB Uzbek |
| <input type="checkbox"/> VIE Vietnamese | <input type="checkbox"/> WOL Wolof | <input type="checkbox"/> YOR Yoruba |

STUDENT HEALTH HISTORY – to be completed by parent/guardian

Student Name _____	DOB _____	Grade _____
Parent/Guardian Name _____		School _____
Address _____		Phone _____

HEALTH CONDITIONS – Check all that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> Abnormal Spinal Curvature/Scoliosis
<input type="checkbox"/> Allergies ___ food ___ medication ___ bees
___ seasonal
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma Inhaler? ___yes ___no
<input type="checkbox"/> Behavior problems
<input type="checkbox"/> Birth or congenital malformation
<input type="checkbox"/> Cancer type _____
<input type="checkbox"/> Chickenpox
<input type="checkbox"/> Concerns about siblings/friend relationships
<input type="checkbox"/> Diabetes type _____ insulin? ___yes ___no | <input type="checkbox"/> Diarrhea ___ Constipation
<input type="checkbox"/> Eating disorder/concerns
(anorexia/bulimia, etc)
<input type="checkbox"/> Eczema
<input type="checkbox"/> Emotional problems
<input type="checkbox"/> Headaches (frequent)
<input type="checkbox"/> Heart disease
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Measles (10 day)
<input type="checkbox"/> Meningitis or Encephalitis
<input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Rubella (3 day measles)
type _____
<input type="checkbox"/> Seizures/Epilepsy
treatment _____
<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Skin rashes (frequent/chronic)
<input type="checkbox"/> Stool soiling
<input type="checkbox"/> Throat infections (frequent)
<input type="checkbox"/> Tics/nervous twitches
<input type="checkbox"/> Urinary Tract Infections
<input type="checkbox"/> Wetting ___ day ___ night |
|--|--|--|

Describe items checked:

VISION AND HEARING HISTORY

Frequent ear infections? ___yes ___no Ear ___left ___right Reduction in hearing? ___yes ___no Ear ___left ___right
 PE Tubes? ___yes ___no In place now? ___yes ___no Wears ___glasses ___contacts ___patch/es

INJURIES AND ILLNESSES – Describe any SEVERE injury and/or illness and include age

MEDICATION – Indicate below any medication taken regularly and why

	Name of Medication	Reason for Medication
<input type="checkbox"/> Daily ___ Frequently	_____	_____
<input type="checkbox"/> Daily ___ Frequently	_____	_____
<input type="checkbox"/> Daily ___ Frequently	_____	_____

ALLERGIES – Indicate below if applicable.

Life Threatening?	Allergic To	Treatment	Medication Needed at School?
<input type="checkbox"/> yes ___ no	_____	_____	_____
<input type="checkbox"/> yes ___ no	_____	_____	_____
<input type="checkbox"/> yes ___ no	_____	_____	_____

ACTIVITY LEVEL ___very active ___normally active
 ___inactive

INTERACTION – Concerns about social development?
 ___yes ___no

COMMENTS/CONCERNS – If there are other concerns regarding your child's health, development, behavior, history or home life that you would like to share with the school, please explain below.

Would you like school health staff to contact you? ___yes ___no

Parent/Guardian Signature _____ Relationship to Student _____ Date ____/____/____

EMERGENCY MEDICAL AUTHORIZATION

Student Name _____ DOB _____ Grade _____

Address _____ School _____

PURPOSE: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached.

LIST NAMES TO CONTACT IN CASE CHILD BECOMES ILL/INJURED:

Residential Parent/Guardian *Name (print)* *Daytime Phone* *Other Phone*

Mother/Guardian _____

Father/Guardian _____

Relative/ChildCare _____

Other/Relationship to student _____

Other/Relationship to student _____

NOTE: PART I or PART II MUST BE COMPLETED AND SIGNED

PART I: To Grant Consent - I hereby give consent for the following medical care providers and local hospital to be called

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist _____ Phone: _____

Local Hospital: _____ Phone: _____

Other: _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by above named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and
2. transfer of the child to 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 such surgery. Facts concerning the child's medical history including allergies (life threatening), medications being taken and any physical impairments to which a physician should be alerted:

Allergies: _____

Medication: _____

Physical Impairments: _____

Asthma? Yes No Diabetes? Yes No Seizures? Yes No

Parent/Guardian Signature _____ Date ____/____/____

PART II: Refusal of Consent - I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Parent/Guardian Signature _____ Date ____/____/____

STUDENT PHOTO/IMAGE RELEASE AUTHORIZATION

It is the policy of the Brecksville-Broadview Heights School District to authorize the Board of Education, its officials, employees, agents, etc., to consider a student's photograph image as "directory information" and to utilize, release and/or publish it in all school publications, such as the yearbook, student awards/recognitions, student activities, sporting/athletic events, video presentations, news media, district website and the cable television channel.

√ Indicate Choice by Checking One

____ **YES, I DO** give permission for use of my child's photo/image as described above.

____ **NO, I DO NOT** give permission for use of my child's photo/image as described above.

Complete below and sign

Student Name

____/____/____
DOB

Grade

School

Parent Guardian Printed Name

Parent/Guardian Signature

____/____/____
Date

AUTHORIZATION FOR PARENT-STAFF E-MAIL COMMUNICATION

The Brecksville-Broadview Heights City School District provides its staff members with access to electronic mail (e-mail) for educational purposes and District related business. The District believes that access to e-mail and other technological resources provides the ability to gather and disseminate information, as well as to enhance home/school communication.

While e-mail may be the most effective way of communicating with your child's teacher or other staff member, it should not be assumed that e-mail correspondence is entirely private and confidential. The District undertakes a number of measure to ensure the security and integrity of its technological resources. However, e-mail travels over the Internet where unauthorized individuals may be able to access an e-mail exchange between a parent and a staff member. Additionally, an e-mail message may be forwarded to the wrong person or e-mail address. Therefore, it may still be best for parents to utilize another method of communication when informing a teacher of particularly sensitive material or requesting a teacher to provide the same.

The District requires all teachers to abide by an acceptable us policy that governs the use of the District's technological resources, including e-mail correspondence. To assist in protecting the privacy of students, any parent who wishes to communicate with his/her child's teacher or other staff member via e-mail must authorize such communication by providing an e-mail address to be used by the teacher/staff member and agreeing to the terms below.

Subject to these understandings, I wish to communicate with my child's teacher or other staff member via e-mail. The following e-mail address (maximum of 2) is/are the address(es) that I wish any e-mail correspondence relating to my child(ren) to be sent to:

e-mail #1

e-mail #2 (optional)

I understand that the teacher/staff member will not respond to inquiries I make from any other e-mail address. I agree that if the e-mail address(es) I have provided change for any reason, I will notify the teacher/staff member. I further agree to waive any claims, demands or actions against the District, including its employees and agents that may result from the use of e-mail as a means of communication between the District and me.

Parent/Guardian printed name

Children

Parent/Guardian Signature

____/____/____
Date