C.O.O.R. INTERMEDIATE SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION

In the event such an occurrence would happen and I am not available, I request C.O.O.R. Intermediate School District to take: ____

to the nearest doctor, dentist and/or hospital. I authorize said doctor, dentist and/or hospital to provide the necessary emergency medical treatment in accordance with the prescribed medication control sheet on record at C.O.O.R. Intermediate School District.

PARENT/LEGAL GUARDIAN SIGNATURE: ______________________________

DATE: ____________________ PHONE NUMBER: ____________________

ADDRESS: ____

PERSON TO BE CONTACTED IN ABSENCE OF PARENT: ______________________

PHONE NUMBER: ____

ADDRESS: ____

FAMILY PHYSICIAN: ____

PHONE NUMBER: ____

DENTIST: ____

PHONE NUMBER: ____

INSURANCE COMPANY: ____

POLICY NUMBER: ____

MEDICARE NUMBER: ____

MEDICAID NUMBER: ____

C.O.O.R. Intermediate School District
Authorization for Administration of Medication

Name of Student: ______________________________ Birthdate: ____________________

School: ______________________________ Grade: ____________________

Physician's Order:

Student Name: ______________________________

Diagnosis/Purpose of Medication: ______________________________

Name of Medication: ______________________________

Dosage: ____________ Frequency: ____________ Route: ____________ Time: ____________

Anticipated Duration: ______________________________ if indefinite, so state:

This Prescription is:

☐ Initiation of Therapy ☐ Adjustment of Dosage

☐ Maintenance Dose ☐ Discontinuation of Therapy

Comments regarding this Prescription: (include adverse reactions, precautions, etc.)

Physician's Signature: ______________________________ **Date:** ____________

The undersigned parent/guardian authorizes the C.O.O.R. Intermediate School District through its administrators or teachers to administer medication to my child.

It is understood that the undersigned parent/guardian shall immediately notify the school district in writing in the event the prescription shall be discontinued or modified.

The medication must be brought to school in a container appropriately labeled by the physician or pharmacy. Daily carrying of medication is to be avoided. Refill of the prescription shall be the responsibility of the parent/guardian.

Further, the undersigned releases the school district and shall indemnify said school district from any liability or damage which may result to the student from the administration of said medication as prescribed by the physician.

Signature of Parent/Guardian: ______________________________ **Date:** ____________

7/04

C.O.O.R. INTERMEDIATE SCHOOL DISTRICT

AUTHORIZATION FOR ADMINISTRATION OF SHORT-TERM PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS

Student Name: ______________________________ Birthdate: _____________

School: __________________________________ Teacher: _____________

....

I, ___________________________, parent/guardian of ________________________

authorize the administration of the following:

MEDICATION: ____

DOSAGE: ____

TIME(S): ____

DOCTOR: ____

Comments regarding this prescription or over-the-counter medications (Include adverse reaction, precautions, etc.): ____

____

____

....

The undersigned parent/guardian authorizes the C.O.O.R. Intermediate School District through its administrators or teachers, to administer medication or to supervise the taking of medication by my child.

It is understood that the undersigned parent/guardian shall immediately notify the Intermediate School District in writing in the event the prescription shall be discontinued or modified.

Further, the undersigned releases the school district and shall indemnify said Intermediate School District from any liability or damage which may result to the student from the administration of said medication.

______________________________________ ________________________

Signature of Parent(s)/Guardian(s) Date

THIS FORM IS VALID FOR ONE CALENDAR MONTH ONLY

Parent/Guardian:

ren need healthy meals to learn. C.O.O.R. Intermediate School District offers healthy meals every school day. Stud buy lunch for *$2.10* and breakfast for *$1.25*. Your children may qualify for free meals or for reduced price meals. educed price lunches for *$.40* and breakfasts for *$.30*. If a doctor has determined that your child has a disability, isability would prevent the child from eating the regular school meal, the school will make any substitution prescribe tor at no extra charge. For further information, please call Holly Holm @ (989) 275-9550. The doctor's staten ling prescribed diet and/or substitution, must be submitted to the food service department at your school.

. **Do I need to fill out an application for each child?** No. Complete the application to apply for free and red price school meals. Use one Free and Reduced Price School Meals Family Application for all students in household. We cannot approve an application that is not complete, so be sure to fill out all required informa Return the completed application to: ***Holly Holm, CEC Secretary, P.O. Box 827, Roscommon, Michigan 4865***

. **Who can get free meals?** Children in households getting Food Stamps, FIP, or FDPIR and most foster children get free meals regardless of your income. Also, your children can get free price meals if your household incon within the free limits on the Federal Income Guidelines.

. **Can homeless, runaway, and migrant children get free meals?** Please call *George Johnson @ (989) 275-9* homeless liaison or migrant coordinator to see if your child(ren) qualify if you have not been informed that they get free meals.

Who can get reduced price meals? Your children can get low cost meals if your household income is within reduced price limits on the Federal Income Chart shown on this application.

Should I fill out an application if I got a letter this school year saying my children are approved for fre reduced price meals? Please read the letter you got carefully and follow the instructions. Call the school at (9 275-9550 if you have questions.

I get WIC. Can my child(ren) get free meals? Children in households participating in WIC may be eligible free or reduced price meals. Please fill out an application.

Will the information I give be checked? Yes, we may ask you to send written proof.

If I don't qualify now, may I apply later? Yes. You may apply at any time during the school year if y household size goes up, income goes down, or if you start getting Food Stamps, FIP, FDPIR, or other benefits. If lose your job, your children may be able to get free or reduced price meals.

What if I disagree with the school's decision about my application?
You should talk to school officials. You also may ask for a hearing by calling or writing to: *George Johnson, 11 North Cut Road, P.O. Box 827, Roscommon, Michigan 48653, (989) 275-9526*.

). **May I apply if someone in my household is not a U.S. citizen?** Yes. You or your child(ren) do not have to b U.S. citizen to qualify for free or reduced price meals.

l. **Who should I include as members of my household?** You must include all people living in your househ related or not (such as grandparents, other relative, or friends). You must include yourself and all children who with you.

!. **What if my income is not always the same?** List the amount that you normally get. For example, if you norm get $1000 each month, but you missed some work last month and only got $900, put down that you get $1000 month. If you normally get overtime, include it, but not if you get it only sometimes.

3. **We are in the military: do we include our housing allowance as income?** If your housing is part of Milit Privatization Initiative, do not include your housing allowance as income. All other allowances must be include your gross income.

4. **What if my child does not have health insurance?**
Your children may qualify for low cost or free health insurance through MIChild and Healthy Kids Program. To Ap On-line, go to www.michigan.gov/michild or call 1-888-988-6300 for help or to request a paper application.

Sincerely,
Holly Holm, CEC Secretary

Total Family Size	Annual	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$18,889	$1,575	$788	$727	$364
2	$25,327	$2,111	$1,056	$975	$488
3	$31,765	$2,648	$1,324	$1,222	$611
4	$38,203	$3,184	$1,592	$1,470	$735
5	$44,641	$3,721	$1,861	$1,717	$859
6	$51,079	$4,257	$2,129	$1,965	$983
7	$57,517	$4,794	$2,397	$2,213	$1,107
8	$63,955	$5,330	$2,665	$2,460	$1,230
*For each additional household member add:	$ 6,438*	$ 537*	$ 269*	$ 248*	$ 124*

lication Instructions:

r children may qualify for free or reduced e meals if your household income falls in the limits on this chart.

ur entire household receives Stamps, FIP, or FDPIR, follow these ıctions:

: Skip this part.
: Skip this part.
: If the student is new to the district/school check "Yes." List student(s) name, school, grade, check "Yes," and list a case number.
: Skip this part.
: Sign and date the form. A social security number is not necessary.
: Answer this question if you choose to.

are applying for a homeless, migrant, or runaway child check the appropriate box and contact your Homeless Liaiso ıt Coordinator. Fill out application by following instructions for ALL OTHER HOUSEHOLDS.

ı are applying for a FOSTER CHILD, follow these instructions:

: Check the box and list the child's personal use monthly income, if any.
: Skip this part.
: **Use a separate application for each foster child.** List the child's name, school, and grade.
: Skip this part.
: Sign and date the form. A social security number is not necessary.
: Answer this question if you choose to.
: Answer this question if you choose to.

THER HOUSEHOLDS, including WIC households, follow these instructions:

: Skip this part.
: Check the appropriate box, if any.
: If the student is new to the district/school check "Yes." List each student(s) name, school, and grade.
: Follow these instructions to report total household income from last month.

Column 1- Name:
List the first and last name of **each** person living in your household, related or not (such as grandparents, ot relative, or friends). You must include yourself and all children living with you. Attach another sheet of paper if need to.

Column 2- Gross Income:
Next to each person's first and last name list each type of income received last month. Next to the amount circle h often the person got it (weekly, every other week, twice a month, or monthly).

- *Earning from work:* List the gross income each person earned from work. This is not the same as take-ho pay. **Gross income is the amount earned before taxes and other deductions.** Net income shc **ONLY** be reported for self-owned business, farm, or rental income.
- *All other income:* List the amount each person got last month from welfare, child support, and alimony in second column. List the amount each person got last month from pensions, retirement, and Social Securit the third column. List All Other Income sources in the fourth column. All Other Income includes Work Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (benefits), disability benefits, regular contributions from people who do not live in your household, and A OTHER INCOME.
- If the person does not have any income, circle "NO" in the last column "Circle if NO income."

: An adult household member must sign and date the form, and list a **social security number** or check the box "I not have a social security number."
: Skip this part.
: Answer this question if you choose to.

STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH

LANSING

ENNIFER M. GRANHOLM
GOVERNOR

IMMUNIZATION WAIVER FORM

TRUCTIONS TO PARENTS OR GUARDIANS:

cine-preventable diseases are still with us. In many cases, they cause disability or death. Immunizations are one of our most cost-ctive measures to protect children from harmful disease. A high proportion of children must be immunized to prevent outbreaks of ase in school settings and other places where children work and play closely together.

tions 9208 and 9211 of the Michigan Public Health Code require that a parent, guardian, or person in *loco parentis* applying to have a d registered for the first time in a Michigan school or in a program of group residence, care, or camping in this state shall present to cials at the time of registration or not later than the first day of school or program enrollment, a certificate of immunization verifying the child has been vaccinated against diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, hepatitis B, and varicella ckenpox). Vaccination for *Haemophilus influenzae* type b is also required for preschool-aged children.

arent or guardian wishing to exempt his or her child from a particular vaccination must provide a written statement indicating the gious or philosophical objections to the vaccination(s). A child who has been exempted from a vaccination is considered susceptible t disease or diseases for which the vaccination offers protection. The child may be subject to exclusion from the school or program, i local and or state public health authority advises exclusion as a disease control measure.

igning this waiver, you acknowledge that you are placing your child and others at risk of serious illness should he or she contrac sease that could have been prevented through proper vaccination.

INFORMATION MUST BE FILLED IN BELOW.

ject to having my child, ____________________________, born __________________, immunized against the ases I have checked below: *(First & Last Name)* *(Birth Date)*

☐	*Diphtheria*	☐	*Measles*	☐	*Polio*
☐	*Tetanus*	☐	*Mumps*	☐	*Hepatitis B*
☐	*Pertussis*	☐	*Rubella*	☐	*Haemophilus influenzae type b*
☐	*Varicella (chickenpox)*				

son: ____

____

ent(s)/Guardian(s) Name: ____________________________________

ress: ________________________ *Telephone:* __________________

'd's Address: ________________________ *Telephone* __________________
If different from parent/guardian

______________________________ ______________
rent or Guardian's Signature *Date Signed*

____
school Program or Licensed Day Care Center OR School Name ***(Required)***

'e in the child's permanent record and attach a copy to the IP-100 or IP-101 report that is sen the local health department

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

NNIFER M. GRANHOLM
GOVERNOR

Medical Contraindication Form

Michigan immunization law requires that a child enrolled in a school or child care center be immunized against the diseases specified unless a valid exemption applies. A child is exempt from these requirements for any specific immunization for any period of time for which a physician certifies that a specific immunization is or may be detrimental to the child's health. Any child with a medical contraindication to a particular vaccination i considered susceptible to that vaccine-preventable disease, and is subject to exclusion from school or center if an outbreak of the disease occurs in the school or center.

PLEASE PRINT:

NAME OF CHILD (Last, First, Middle Initial)	BIRTH DATE (Mo/Day/Yr)

Preschool Program Or Child Care Center or School Name:

The following immunization(s) are medically contraindicated and constitute a threat to the child's health:

Reason for exemption____

____

____

The exemption shall continue until (Mo/Day/Yr): ____________________________

PRINT NAME & ADDRESS OF PHYSICIAN	TELEPHONE
	( )
PHYSICIAN'S SIGNATURE	DATE

File in the child's permanent record and attach a copy to the IP-100/101 form.