Perry Public Schools K-12 Online Learning Agreement
(Required of all Students)

This agreement is required for all students regardless of whether they receive face-to-face or online instruction. For those students who are receiving instruction in the classroom, it is our intent that they will continue to be in the classroom, however, if circumstances arise that require the need to deliver instruction online virtually this form will serve as permission to provide online instruction to your students in the event of a mandated school closure.

FOR HIGH SCHOOL STUDENTS ONLY - While all students will take either face-to-face or online classes through **Perry High School teachers, special circumstances may also arise in which students must take a School Board or State approved online class through a third party. Please initial here granting your permission for third party online education. **PARENT INITIALS** _____

The purpose of this agreement is to acknowledge acceptance of the identified roles and responsibilities for students and parents who access online courses through Perry Public Schools.

Student Name	**Grade**	**Email**
_____	_____	_____
Parent/Guardian Name	**Phone Number**	**Email**
_____	_____	_____

Student

- I agree to develop and maintain a study schedule.
- I agree to keep up with assignments, tests and quizzes.
- I agree to communicate with my instructor on a regular basis.
- I agree to communicate regularly with my parents/guardians and whenever I have a problem.

Parent

- My child has access to a computer with Internet connection at home (personal or district provided).
- I agree to support my student's success in online learning by:
  - Monitoring his/her progress through the district's learning management system.
  - Helping maintain his/her study schedule
  - Encouraging him/her to communicate with the instructor whenever he/she has a question or a problem.

School Responsibilities

We, as teachers, will share the responsibility to improve all students' academic achievement and achieve the state's high standards. Perry staff will:

- Provide high-quality curriculum and instruction in a supportive and effective learning environment that enables the participating children to meet the State's student academic achievement standards.
- Hold parent-teacher conferences.
- Provide parents with frequent reports on their children's progress.
- Provide parents reasonable access to staff.
- Provide parents opportunities to actively engage with child's learning.

We acknowledge that we have reviewed this agreement together and understand our responsibilities.

Student _____ Date_____

I give my child permission to enroll in online learning through Perry Public Schools

Parent/Guardian _____ Date_____

Perry Public Schools

Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools, 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 students 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 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 **Perry Public Schools** *to release my child's immunization record 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: ___/___/___

Signature of Parent/Guardian
or Eligible Student: _____ Date: ___/___/___

Printed Parent/Guardian Name: _____

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 II 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 NAME (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

Yes	No	#	Is your child having any of the problems listed below?	Birth History:
□	□	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)	Are there any current or past diagnosis (es)? □ Yes □ No
□	□	8	Trouble with Passing Urine or Bowel Movements	If yes, please describe:
□	□	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?	If yes, list medications:
			Reason for Medication	
			/ /	Was the health history reviewed by a health professional?
			Parent/Guardian Signature (Date)	□ 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

Age	Age	Was child tested for	Test results	Normal	Abnormal	Refer to	Age	Age	Was child tested for	Test results	Normal	Abnormal	Refer to
□	□	VISION	Visual Acuity				□	□	HEIGHT & WEIGHT	Height			
□	□		Muscle Imbalance							Weight			
		Date / /	Other				□	□	Other	Other			
□	□	HEARING	Audiometer				□	□	HEMOGLOBIN/HEMATOCRIT	⇨			
			Other										
		Date / /					□	□	BLOOD PRESSURE	Reading			
□	□	URINALYSIS	Sugar				□	□	TUBERCULIN	Type			
			Albumin										
		Date / /	Microscopic						Date / /	Neg. □ Pos. □ mm			
□	□	BLOOD LEAD LEVEL					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 these same intervals as listed above.						
		Date / /	Level _____ ug/dl			⇨							

Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: / /