OFFICE USE ONLY

Start Date _____

Teacher _____

Student ID _____

Lunch ID _____

UIC Number _____

STUDENT FORMS LIST

Student Name: _____

Grade 2024-2025: _____

_____ Student Application

_____ Photo Release

_____ Special Education Information

_____ Request for Student Special Education Records

_____ Request for Student Records

_____ Allergy List

_____ Medical Condition

_____ Medical Release

_____NEW*KDG ORAL HEALTH ASSESSMENT (Kindergarten Only)

_____ Health Appraisal (Kindergarten Only)

_____ Pesticide Notification Form

_____ Concussion Wavier Form

_____ Child Information Record

_____ Home Language Survey

_____ Technology Form

_____ Compact

_____ Conduct

_____ **CEP Household Survey**

_____ **Immunization Records/ Ferpa Consent**

_____ **Copy of Birth Certificate**

_____ **Copy of Driver's License**

_____ **Copy of Current IEP**

_____ **Discipline Report & Student Records Received**

EAST SHORE LEADERSHIP ACADEMY (ESLA) 2024-2025
STUDENT APPLICATION

Student Name: (first/last) _____

Address: _____

_____

Date of Birth _____ Age _____ Gender _____

Last School Attended: _____

Grade in which student is enrolling at ESLA: _____

Ethnicity/Race: (***Check all that apply***)
African American _____ American Indian _____ Caucasian _____ Hispanic _____
Multi-racial _____ Other _____

Language spoken in home: _____ Child's primary language: _____

Parent(s)/Guardian(s) Name:

_____ _____

Home Phone _____ Home Phone_____

Cell Phone_____ Cell Phone_____

Email Address_____

Are you living in any of the following locations? ***(Check one)***
Rent/Own _____ Un-Sheltered (on the street) _____ Transitional Housing _____ Foster _____
Doubling-Up _____ Hotel/Motel _____ Unaccompanied Youth _____ Migrant _____
(See office if you have any questions)

How did you hear about ESLA: (mailer, newspaper, billboard, etc) _____

If you were referred to ESLA by a currently enrolled family please list their name:

_____

Other siblings who may attend ESLA: (name/grade)

_____ _____

_____ _____

Photo/Video Release:

Permission to have your child's photo/video/name used for any type of internal/external marketing: (website, school building, newspaper, mailer, etc.).

Yes _____ No _____

_____ _____

Signature of Parent or Guardian Enrolling Student ***Date***

1403 7th Street Port Huron, MI 48060
Phone: 810-294-8040 Fax: 810-990-8943

2024-2025 ENROLLMENT
STUDENT REQUEST FOR SPECIAL EDUCATION RECORDS

Student Information

Last name: _____ First name: _____ M.I.: _____

Maiden/Former Name: _____ Birth Date: _____

Last school attended: _____ Year of Graduation: _____

Information you are requesting:

_____ IEPs (Sp. Ed. - Current/Past) _____ Other: _____

_____ MET/3 yr. Evaluations (Sp. Ed.) _____ Other: _____

_____ Tests (Sp. Ed.) _____ Other: _____

Name of Requesting Person, Organization, and Representative: East Shore Leadership Academy

☐ Parent ☐ Adult Student ☐ Legal Guardian ☐ Agency/Organization

Address:

_____

City: _____ State: _____ Zip: _____

Email: _____ Phone Number: _____

Signature: _____ Date: _____
Parent, legal guardian, eligible student

The above listed individual will be required to present photo identification upon retrieving the copied record. Requesting person/organization, if not parent, legal guardian, eligible student must attach documentation-evidencing representation of the ESLA Special Education Student (i.e. signed release). In accordance with 300.407 we will respond to any records without unnecessary delay.

For office use only: Served by: _____

Date Received: _____ *Type of ID provided:* _____

_____ Waited For _____ Picked Up _____ Other: _____

1403 7th Street Port Huron, MI 48060
Phone: 810-294-8040 Fax: 810-990-8943

2024-2025 ENROLLMENT
SPECIAL EDUCATION INFORMATION

Student Name: _____

_____ _____ _____
Date of Birth (mm/day/yr) ***Age*** ***Grade***

Does your child qualify for Special Education? _____

Does your child have a current IEP? _____

Does your child have a current 504 plan? _____

Please check any boxes that apply to your child's **current** educational needs and areas of weakness:

- ☐ Reading
- ☐ Writing
- ☐ Math
- ☐ Speech/Language
- ☐ ADHD (Hyperactivity)
- ☐ Visual Impairment
- ☐ Hearing Impairment
- ☐ Emotional Impairment
- ☐ Other Mental Impairment (Down Syndrome, etc.)

☐ Other_____

Has your child been expelled in the past? _____

Date(s): _____

Reason(s): _____

Has your child been retained? _____

Which grade(s) _____

Signature of Parent/Legal Guardian ***Date***

2024-2025 ENROLLMENT
REQUEST FOR RECORDS

Student Information

Student Name: _____

Address: _____City:_____St:_____Zip:_____

Phone Number: _____ Date of Birth: _____

☐ Male
☐ Female

School Releasing Information

School Name: _____

Address: _____ City: _____ St: ____ Zip: _____

School Phone Number: (_____)_____

Records Requested

CA60 with all records/grades, etc. including but not limited to IEP's, Immunization Records, etc.

School Transfer Weapons Free School Zone Statement

The above student is currently enrolled at East Shore Leadership Academy. In order to comply with Public Act 328, please verify that he/she has not been suspended or expelled from school for a weapons violation subsequent to January 1, 1999. If the above has been suspended or expelled due to weapons violation, please attach an explanation as to the current status of the student.

Parent/Guardian Signature ***Date***

1403 7TH Street ·Port Huron, MI 48060 ·Phone (810)294-8040 · Fax (810)990-8943
Website www.EastShoreLeaders.com
Facebook www.facebook.com/EastShoreLeaders

2024-2025 ENROLLMENT
ALLERGY LIST

Student's Name: _____

Teacher's Name: _____

- ☐ Yes, my child **has** allergies.
- ☐ No, my child **does not have** allergies.

List allergies in detail:

_____

_____

_____

_____

_____

_____

_____

_____

Parent/Guardian's Signature Date

1403 7TH Street · Port Huron, MI 48060 · Phone (810)294-8040 · Fax (810)990-8943
Website www.EastShoreLeaders.com
Facebook www.facebook.com/EastShoreLeaders

2024-2025 ENROLLMENT
MEDICAL CONDITION

Student Name: _____

Teacher Name: _____

☐ Yes, my child **has** a Medical Condition

☐ No, my child **does not have** a Medical Condition

List Medical Condition in detail:

_____

_____

_____

_____

Please attach any relative information regarding the Medical Condition(s)

_____

Parent/Guardian Signature ***Date***

1403 7TH Street · Port Huron, MI 48060 · Phone (810)294-8040 · Fax (810)990-8943
Website www.EastShoreLeaders.com
Facebook www.facebook.com/EastShoreLeaders

2024-2025 ENROLLMENT
MEDICAL RELEASE

I, _____ **DO NOT HOLD**
(Parent/Guardian's Name)
East Shore Leadership Academy responsible for accidentally forgetting to administer medication to my child _____.
(Child's Name)

I understand that Staff Members can forget and I take this risk by asking _____ to give the medication.
(Educator's Name)

If I want to ensure that my child receives the medication, I have the right to come into the school and administer this medication to my child.

_____

Parent/Guardian's Signature ***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 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	Resolved	# 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:

_____ / / 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

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
		Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN Date: / /	Type: _____ Neg.: ☐ Pos.: ☐ _____ mm			

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.

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

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

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 (HPV9/HPV4/HPV2)	1	3
	2	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	1	
	2	
	3	

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 provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

Parent/Guardian refused immunizations: ☐

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	
☐	☐	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:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ 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.

****

Developed in Cooperation with the Department of Health and Human Services, Education, 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.

Parent/Guardian,

PESTICIDE ALERT
2024-2025

As part of East Shore Leadership Academy's pest management program, pesticides are occasionally applied. You have the right to be informed prior to any pesticide application made to the school grounds and buildings. In certain emergencies, pesticides may be applied without prior notice, but you will be provided notice following any such application. If you need prior notification, please complete the information below and submit to:

East Shore Leadership Academy Main Office

Pesticide Prior Notification Request

Parent/Guardian Name: _____

Student's Name: _____

Street: _____ City: _____ Zip: _____

Telephone: _____

( ) I wish to be notified prior to a scheduled treatment inside the building.

( ) I wish to be notified prior to a scheduled pesticide treatment on the outside of the school.

( ) Both of the above

Announcements of pesticide treatment may be included in the newsletter and on the school's website.

PARENT & ATHLETE CONCUSSION INFORMATION SHEET

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. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

[INSERT YOUR LOGO]

"IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON"

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. An athlete 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)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

STUDENT-ATHLETE NAME PRINTED

STUDENT-ATHLETE NAME SIGNED

DATE

PARENT OR GUARDIAN NAME PRINTED

PARENT OR GUARDIAN NAME SIGNED

DATE

HEADS UP

JOIN THE CONVERSATION www.facebook.com/CDCHeadsUp

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

CHILD INFORMATION RECORD

State of Michigan Department of Human Services - Bureau of Children and Adult Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:	Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)				Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State	Zip Code

Father/Legal Guardian's Name	Home Phone ( )	Mother/Legal Guardian's Name	Home Phone ( )
Home Address (if not child's address)	Cell Phone ( )	Home Address (if not child's address)	Cell Phone ( )
City / State / Zip Code		City / State / Zip Code	
Email Address (optional)		Email Address (optional)	
Employer Name	Work Phone ( )	Employer Name	Work Phone ( )
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ( )	
Hospital Preferred for Emergency Treatment (optional)			
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)			

BCAL-3731 (Rev. 7-12) Previous editions 9-09, 3-08, 10-07, & 1-06 may be used until 12/31/13. **See Reverse Side**

Emergency Contact & Release of Child: List all individuals,including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	( )	2.	( )
3.	( )	4.	( )

I give permission to _____ , licensed by the Department of Human Services
(Provider's Name)

to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.

Signature of Parent or Guardian	Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 7-12) Previous editions 9-09,3-08, 10-07, & 1-06 may be used until 12/31/13.

2024-2025 ENROLLMENT
HOME LANGUAGE SURVEY

East Shore Leadership Academy is collecting information regarding the language background of each of its students. This information will be used by the district to determine the number of children who should be provided bilingual instruction according to Sections 380.1152 – 380.1157 of the School Code of 1995, Michigan's Bilingual Education Law. Would you please provide the following information:

Thank you for your cooperation.

Name of Student: _____ Grade _____Age _____

Name of School: East Shore Leadership Academy

1. Is your child's native tongue a language other than English? Yes _____No _____
   What is that language? _____

2. Is the primary language used in your child's home or environment a language other than English? Yes _____No _____

   What is that language? _____

Signature of Parent/Guardian: _____

Date: _____

Address: _____

_____

[1]"Primary language" means the dominant language used by a person for communication.
* Translation of this survey form in Spanish, Arabic, French, Italian and Ojibwa is available at the Office of Field Services at 517-373-6066.

ACCEPTABLE USE AGREEMENT: INTRANET/INTERNET

Grades K- 2 ,*

~~Including Summer School~~
~~(Renewable in Grades 3, 6 & 9)~~

KDG -2nd Grade Agreement Follows
Onto Next School Grade

As a part of my schoolwork, my school gives me the use of computers and storage space on the server for my work. My behavior and language are to follow the same rules I follow in my class and in my school. To help myself and others, I agree to the following promises:

1. I will use the computers *only* to do school work, and not for *any other* reason. I will not store material that is not related to my schoolwork.

2. I will use the Internet *only* with my teacher's permission.

3. I will not give my password to anyone else, and I will not ask for or use anyone else's password.

4. I will *not* put on the computer my address or telephone number, or any other personal information about myself or anyone else.

5. I will not upload, link, or embed an image of myself or others without my teacher's permission.

6. I will not play games that a teacher has not approved.

7. I will be polite and considerate when I use the computer; I will not use it to annoy, be mean to, frighten, threaten, tease, bully, or poke fun at anyone; I will not use swear words or any other rude language.

8. I will not try to see, send, or upload anything that says and/or shows bad or mean things about anyone's race, religion or sex.

9. I will not damage the computer or anyone else's work.

10. I will not take credit for other people's work.

11. If I have or see a problem, I will not try to fix it myself but I will tell the teacher.

12. I will not block or interfere with school or school system communications.

13. My teacher may look at my work to be sure that I am following these rules, and if I am not, there will be consequences which may include not being able to use the computer.

14. I know that the conduct that is forbidden in school is also forbidden when I use computers outside of school if it interferes with other students' education, and if I break the rules there will consequences in school.

.

Print Student's Name: _____School: _____Grade: _____

Student's Signature: _____Date: _____

Parents: *I have read and discussed with my child the Acceptable Use Agreement, and I give permission for his or her use of the resources. I understand that computer access is conditional upon adherence to the agreement. Although students are supervised using computers, and their use is electronically monitored, I am aware of the possibility that my child may gain access to material that school officials and I may consider inappropriate or not of educational value.*

Print Parent's Name: _____

Parent's Signature: _____Date: _____

*** STUDENTS MAY NOT USE COMPUTERS UNLESS**
THIS AGREEMENT IS SIGNED AND RETURNED TO THE TEACHER.

ACCEPTABLE USE AGREEMENT: INTRANET/INTERNET

Grades 3 - 8*

~~**Including Summer School**~~

~~**(Renewable in grades 6 & 9)**~~

3rd-8th Grade Agreement Follows Onto Next School Grade

As a part of my schoolwork, my school gives me the use of computers and storage space on the server for my work. My behavior and language should follow the same rules I follow in my class and in my school. To help myself and others, I agree to the following promises:

1. I will use the computers *only* to do school work, as explained to me by my teacher and not for *any other* reason. I will not use a school computer for personal or illegal purposes.

2. I will use the Internet *only* in ways the teacher has approved.

3. I will not give my password to anyone else, and I will not ask for or use anyone else's password.

4. I will *not* put on the computer my address or telephone number, or any other personal information about myself or anyone else.

5. I will not upload, link, or embed an image of myself or others to non-secured, public sites.

6. I will not use games or other electronic resources that have objectionable content or that engage me in an inappropriate simulated activity.

7. I will be polite and considerate when I use the computer. I will not use it to annoy, be mean to, frighten, tease, or poke fun at anyone. I will not use swear words or other rude language.

8. I will not use the computer to bully or threaten anyone, including teachers, schoolmates or other children.

9. I will not try to see, send, or upload anything that says and or shows bad or mean things about anyone's race, religion or sex.

10. I will not damage the computer or anyone else's work.

11. I will not break copyright rules or take credit for anyone else's work.

12. If I have or see a problem, I will not try to fix it myself but I will tell the teacher. *If the problem is an inappropriate image I will turn off the monitor and then seek help.*

13. I will not block or interfere with school or school system communications.

14. My computer use is not private; my teacher may look at my work to be sure that I am following these rules, and if I am not, there will be consequences which may include not being able to use the computer.

15. I know that the conduct that is forbidden in school is also forbidden when I use computers outside of school if it interferes with other students' education, and if I break the rules there will be consequences in school.

Print Student's Name: _____**School:** _____**Grade:** _____

Student's Signature: _____**Date:** _____

Parents: *I have read and discussed with my son or daughter the Acceptable Use Agreement, and I give permission for him or her to use these resources. I understand that computer access is conditional upon adherence to the guidelines above. Although students are supervised when using these resources, and their use is electronically monitored, I am aware of the possibility that my son or daughter may gain access to material that school officials and I may consider inappropriate or not of educational value.*

Print Parent's Name: _____

Parent's Signature: _____**Date:** _____

*** STUDENTS MAY NOT USE COMPUTERS UNLESS**

THIS AGREEMENT IS SIGNED AND RETURNED TO THE TEACHER.