

SCHOOL YEAR 23-24



Milford Extended Day STUDENT REGISTRATION FORM School Year 2023-2024

Office Use Only
Reg Fee PD <input type="checkbox"/>
Date Received _____
Teacher _____
SN <input type="checkbox"/>

Student ID # _____ School: _____ Grade for School Year 23-24 _____

Last Name _____ First Name _____ Middle Name _____

Preferred Name _____ Sex of Student Male Female Native Language _____

Date of Birth _____ Home Phone _____

Special Services IEP 1:1 Aide

Does the child receive Special Services? _____

May your child's photo be taken and displayed? Yes No

May your child be listed on a roster? Yes No

Handbook received? Yes No Use Online? Yes No

Legal Guardianship

Are you the biological/adoptive parent(s) of the child? Yes No

If no, what is your relationship to the child? _____

Status of BIOLOGICAL/ADOPTIVE Parents Married Divorced Widowed Separated Single/Never Married

If divorced, who has legal custody? Mother Father Shared Parenting

If foster/guardian, please list Case Manager/Court Liaison _____

Do you have legal papers? Yes No

Please complete information on father and mother, including contact numbers, regardless of marital status.

Circle: Father/Guardian/Foster Parent

Resides Here Contact about Payment

Name: _____

Address: _____ City _____ State _____ ZIP _____

Home Phone: _____ Cell Phone: _____

Name of Employer: _____ Business Phone: _____

Circle: Mother/Guardian/Foster Parent

Resides Here Contact about Payment

Name: _____

Address: _____ City _____ State _____ ZIP _____

Home Phone: _____ Cell Phone: _____

Name of Employer: _____ Business Phone: _____

Preferred Email Address _____ 2nd Email address _____

Step-Parent Father _____ Work/Cell Phone _____

Step-Parent Mother _____ Work/Cell Phone _____

Emergency Number: _____

Monthly statements will be emailed. Please provide email address above.

Siblings

Name	Age	Grade	Lives with...
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Authorized Pick Up List (other than parents)

Name

Relationship

Home#

Cell#

Work#

Name

Relationship

Home#

Cell#

Work#

Name

Relationship

Home#

Cell#

Work#

Name

Relationship

Home#

Cell#

Work#

SY 23-24 EXTENDED DAY PROGRAM AGREEMENT (Grades KDG-6)

The Parent/Guardian of (student name) _____ and the Milford Exempted Village School hereby agrees to the following participation provisions of the Milford Extended Day Program:

Parent/guardian will pay a weekly Child Care fee of \$ _____ for their child to attend the indicated days per week. Make payments by Visa, MasterCard, Discover, or American Express at www.payschoolscentral.com, by check, or by money order payable to MILFORD BOARD OF EDUCATION. **(NO CASH PLEASE)**

Child Care payments are **due Friday a week in advance, this includes All Day Care fees.** Payments are accepted at all sites, Milford Extended Day Office, or through mail. Failure to stay current on your account will result in dismissal from the program.

At the time of registration, a nonrefundable \$65 registration fee must be paid for Grades KDG-6.

Late Pick Up Fee: The program closes at 6:30 p.m. After 6:30, you will be charged \$20 per child for every 10 minutes or portions thereof, until your child is picked up. Continual late occurrences could jeopardize your position in the program.

All medical conditions or special concerns that may affect the child's welfare while participating in the Milford Extended Day Programs should be disclosed by parents at the time of registration.

I understand and agree with the provisions of this agreement. I will abide by these and other regulations of the Milford Extended Day programs as presented in the Parent Handbook while my child is a participant in the program. The Parent Handbook can be found online at www.milfordschools.org.

*****Monthly statements emailed. Please email my statement to: _____ ***

Check Box if Parent/Guardian is a Milford Employee _____

Parties responsible for payment must sign.

First Parent Signature _____ Date _____

Second Parent Signature _____ Date _____

A.M. Session
Sign in time _____

P.M. Session
Sign out time _____

____ 3 days per week (circle) M T W TH F
____ 4 days per week (circle) M T W TH F
____ 5 days per week (circle) M T W TH F

____ 3 days per week (circle) M T W TH F
____ 4 days per week (circle) M T W TH F
____ 5 days per week (circle) M T W TH F

MILFORD EXEMPTED VILLAGE SCHOOL DISTRICT EMERGENCY MEDICAL AUTHORIZATION FORM (2023-2024)

(Ohio Revised Code 3313-712)

STUDENT'S NAME _____ STUDENT ID#: _____ GRADE: _____
 STREET ADDRESS _____ DATE OF BIRTH: _____
 CITY, STATE, ZIP _____ PARENT EMAIL: _____

PURPOSE: To enable parents and guardians to authorize the provisions of emergency treatment or transportation for children who become ill or injured while under school authority, or during an emergency situation, when parents cannot be reached. **IF ANY CHANGES OCCUR, NOTIFY THE SCHOOL IMMEDIATELY. (Please PRINT or TYPE, and SIGN the FORM IN THE APPROPRIATE AREAS.)**

PARENT/LEGAL GUARDIAN:

Student lives with: (please check) and enter information below:

- Both Parents Mother only Father only Shared Parenting Foster Parent Other _____

NAME	RELATIONSHIP	CELL PHONE	HOME PHONE	WORK PHONE

List three (3) names of people to be contacted in the EVENT OF AN EMERGENCY:

I understand that my child may be released to anyone on the list if ill, injured, or if an emergency occurs, and he/she must leave school.

NAME	RELATIONSHIP	CELL PHONE	HOME PHONE	WORK PHONE

Please provide detailed information regarding any medical problems, allergies, special needs: _____

Medication your child takes daily: _____

For educational purposes, special medical problems, physical impairments or other facts concerning your child's medical history may be shared with teachers or other support staff involved in the academic setting. If you **DO NOT CONSENT** for the sharing of this information, you are required to state this in writing and submit your statement with this form to your school administrator.

PART I OR PART II MUST BE COMPLETED- (complete ONE SECTION ONLY)

PART I: TO GRANT CONSENT

PART II: REFUSAL TO GRANT CONSENT

(A) I hereby **GIVE MY CONSENT** for the following medical care providers and local hospital to be called:

I **DO NOT GIVE MY 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 the following action:

DOCTOR: _____ Phone: _____

DENTIST: _____ Phone: _____

HOSPITAL: _____ 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 doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the 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.

(B) I authorize Milford Exempted Village School District to release any information which I have provided this school district concerning any medical history, including information regarding allergies, medications, physical condition, etc. of the student named above to any employee of the school district and/or volunteer providing medical service to the school district who has responsibility for such student while the student is at school, participating in a school sponsored function, or is being transported by the school.

SIGNATURE OF PARENT/LEGAL GUARDIAN/
or STUDENT (IF 18 YEARS OR OLDER)

DATE

SIGNATURE OF PARENT/LEGAL GUARDIAN/

DATE

Date School Rec'd _____ Date Trans Rec'd _____ School Year _____

MILFORD EXEMPTED VILLAGE SCHOOL DISTRICT

ALTERNATE TRANSPORTATION/SITTER REQUEST FORM

Grades all Day Kindergarten – 12th

Milford Exempted Village School District

5934 Buckwheat Road, Milford, Ohio 45150

Telephone (513) 575-1563 Fax (513) 575-1658

Transportation cannot be provided if your child's sitter lives outside your school attendance area. Please allow five (5) working days to process your request. We are unable to honor telephone requests for alternate pick up and drop off locations due to liability. Please notify transportation if any information on this form changes.

Student Name _____ School _____ Grade _____

Student Address _____

Parent/Guardian Name _____ Teacher's Name _____

Telephone Numbers of parent (home) _____ Work _____ cell _____

Name of daycare or sitter Milford Extended Day Program Telephone 513-831-9690 cell _____

Sitter's address 1039 St. Rt. 28 Milford, OH 45150

Parent/Guardian Signature _____ Date _____

All schedules must be Monday Through Friday. No exceptions.

Grades ALL DAY KDG through 12 Date Request Begins _____

A.M. Pick-Up Location _____ **M T W T H F Bus** _____ **Time** _____

P.M. Drop Off Location _____ **M T W T H F Bus** _____ **Time** _____

Home Stop _____ **Home bus AM** _____ **Home Bus PM** _____

Copy to driver _____ **Copy to Transportation** _____ **Computer assigned** _____
Date and initial Date and initial Date and initial