Montague Township School District

STUDENT REGISTRATION FORM

SCHOOL YEAR: 2018 - 2019

MONTAGUE RESIDENTS:

☐ Half Day Preschool --- Free
☐ AM ☐ PM

☐ Full Day Preschool --- $750/month

☐ Full Day Kindergarten

☐ 1st – 8th Grade

NON RESIDENTS:

☐ Half Day Preschool --- $400/month
☐ AM ☐ PM

☐ Full Day Preschool --- $750/month

Child's Information

Last Name _____
First Name _____ Middle Name _____
PO Box _____ Physical Address _____
City _____ State _____
Zip Code _____ Home Phone _____
Date of Birth _____ Gender Male _____ Female _____
City, State & Country of Birth _____
If ***NOT*** born in the US – first date in a US school _____
Race: American Indian ___ Asian ___ Black ___ Hispanic ___ White ___
Language spoken at home _____

Parent/Guardian Information

Last Name _____ First Name _____
Relationship to child _____
Does child live with you? Yes _____ No _____
If no, Physical Address _____
Mailing Address _____
City, State & Zip _____
Home Phone _____ Cell Phone _____
Work Phone _____ Email _____

Last Name _____ First Name _____
Relationship to child _____
Does child live with you? Yes _____ No _____
If no, Physical Address _____
Mailing Address _____
City, State & Zip _____
Home Phone _____ Cell Phone _____
Work Phone _____ Email _____
Mail Information to each parent/guardian? Yes ____ No ____

Is there a court ordered:
Temporary Restraining Order? Yes _____ No _____ Dated: _____
Permanent Restraining Order? Yes _____ No _____ Dated: _____
Child Custody Order? Yes _____ No _____ Dated: _____
Guardianship? Yes _____ No _____ Dated: _____
If **yes**, a copy **must** be attached to this form.

Does this child have any siblings in this school? Yes ____ No _____ If Yes, please complete below.

Last Name	First Name	Grade/Class

Emergency Contact/Closing Information (other than parent)
Please notify your emergency contacts that they may be contacted by the school.

1st Contact Name _____
Relationship to child _____
Phone _____ Cell Phone _____
Work Phone _____ Does this person live with student? Yes ___ No ___

2nd Contact Name _____
Relationship to child _____
Phone _____ Cell Phone _____
Work Phone _____ Does this person live with student? Yes ___ No ___

Children will be sent home on their daily/regular bus, unless a parent/guardian calls and notifies the school of different arrangements for that day due to the emergency closing. Due to the critical nature of an early closing, please do not request bus changes in these situations.

All after school programs will be cancelled!

Children that have brought in bus notes to stay after school for an activity will be sent home on their regular buses, unless the school is notified otherwise by a parent/guardian. K.E.E.P. after school care will be notified of emergency dismissals. They will make calls to parents as well. K.E.E.P. children will be sent home on their regular bus (unless the school is notified otherwise by a parent/guardian).

In an emergency closing:

( ) My child(ren) has permission to go directly home on his/her regular bus.
( ) Please hold my child(ren) at school (parent/guardian must arrange pick up).

Please list all persons to whom the child(ren) may be released:
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

MONTAGUE TOWNSHIP SCHOOL DISTRICT
475 Route 206
Montague, NJ 07827
V: 973 293 7131 / F: 973 293 3391
www.montagueschool.org

Timothy Capone
Chief School Administrator/Principal

Tina Palecek
Business Administrator/Bd. Secretary

Alvinna Mheiny
District Secretary

Eric Gumustekin
Assistant to Business Administrator

MONTAGUE NEW STUDENT REGISTRATION

Please provide the requested documents to ensure timely and proper registration of your child.

1. Completion of an entire application packet and medical forms.
2. Current immunization records including hepatitis "B" series record.
3. Copy of Birth Certificate
4. Two (2) proofs of residency with physical street address (One proof must be a NJ Driver's License and/or car registration. PO Box address is not acceptable. A title lease, mortgage agreement, utility bill, or signed contract is acceptable as one proof)
5. Physical Examination Form completed or date of appointment.

Please remember to complete a transfer card with your current school (if applicable).

If you have any questions regarding the registration process, please contact the Montague Township School District at 973-293-7131.

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MONTAGUE TOWNSHIP RESIDENCY

So as not to delay the registration process we are accepting the information you are supplying at the time of registration. This information may or may not be sufficient for us to satisfy our residency requirements. This form, along with your registration form, will be forwarded to my office and given to an administrator for further research and verification, if necessary.

Please check one.

☐ I reside within the Montague Township boundaries. The student I am registering is a full-time resident at that address.

☐ I am not a resident of Montague Township.

If, for any reason, you choose not to sign this form, your son/daughter will not be registered.

If our verification reveals that the address you supplied is not within our boundaries, or you are not living full-time within this District, you understand that you will be notified, the student will be removed from our program, and you will be personally liable for the full tuition payment.

Thank you and welcome to the Montague Township School District.

Timothy C. Capone
Chief School Administrator

Signature: _____
Parent/Guardian

Address: _____

_____

Date: _____

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REQUEST FOR STUDENT RECORDS

Former School Name _____
Address _____
Phone and Fax Number _____

Student's Name _____ Date of Birth _____

Please forward all mandated records for the above-named student who has enrolled in the _____ grade in the Montague Township School District, including the student's State I.D. Number.

In addition, we would appreciate receiving copies of all permitted records, as per parent release below. Please include Federal Lunch Program Application or verification of eligibility, if applicable.

Thank you for your prompt attention to this matter.

Timothy C. Capone
Chief School Administrator

I authorize the release of all permitted records of the above-named student; this includes all CST, IEP's, Speech, health and birth certificates.

_____
Signature of Parent/Guardian

_____
Relationship to Student

_____

_____
Address

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CONSENT AND RELEASE FORM

I am the Parent or Guardian of

Student Name: _____

Class: _____

By signing this form, I give Montague School District permission to publish/display my child's name, image, and schoolwork on school website, World Wide Web, a part of the Internet, newsletters, newspapers, and/or magazines. I understand that copyright and ownership of the work or writing remain my child's property. I also understand that the publication/display of image and schoolwork may include personally identifiable information about my child, such as my child's name, grade level, name of class, and name of school.

I also understand that information published in the newsletters, newspapers, magazines, or Internet may be accessed and distributed by parties over whom Montague School District has no control, and I agree, on myself and my child's behalf, to release Montague Township School District, its board members, administrators, teachers, and employees, from and against any and all claims, damages, or liability arising from or related to the aforementioned publications/displays of my child's name, image, and/or schoolwork.

I have read this Consent and Release form before signing it and I fully understand that my child will not be penalized academically or otherwise if I do not sign it.

Parent/Guardian's Full Name (please print)_____

Parent/Guardian's Signature_____ Date_____

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Grades PreK-8 Acceptable Use Policy

Student Name: _____ Date: _____

I understand that, as an Internet user, I am responsible for acting considerately and appropriately in accordance with the following rules when using the Montague School technology resources:

- I will not send, show, or download inappropriate messages or pictures.
- I will not use bad language.
- I will not insult, annoy, or hurt others.
- I will not damage computers, networks, or other technology equipment.
- I will obey all copyright laws.
- I will not use other users' passwords.
- I will not go into other users' work or files.
- I will not intentionally waste resources like paper, power, or ink.
- I will not access any instant messaging programs like AIM© or Yahoo© instant messenger.
- I will not access any social networking sites like MySpace© or Facebook©.

I understand that any or all of the following could be imposed if I violate any of the policies and procedures regarding the use of Montague School technology resources, including the Internet.

1. Loss of access.
2. Additional disciplinary action taken by the elementary teacher and administration in line with existing district policy.
3. Legal action, when applicable.

My child has my permission to access the Internet under the supervision of a certificated member of the Montague School faculty.

Parent Name: _____ Parent Signature: _____

Student Signature (Grades 2-8 only): _____

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CHILD CUSTODY INFORMATION FORM

(Please complete only if applicable)

The parent with whom the child resides will be considered the custodial parent; however the non-custodial parent has many rights in the absence of an explicit Court Order that limits those rights. It is the responsibility of the custodial parent to provide the school with a copy of any Court Order that limits the custodial rights of the non-custodial parent. Unless specified in the Court Order, the child may be released from school to the non-custodial. It is also expected that the custodial parent will provide the non custodial parent with academic progress information such as report cards or other academic information.

Child's Full Name _____

School child will be attending _____

Name of custodial parent with whom child resides _____

_____

Do you, as the custodial parent, have legal custody through a Court Order?
___ Yes ___ No _____ Pending*

*Date finalization is expected: _____
(If pending, please inform the school when finalized)

If there is a Court Order, does it limit the non-custodial parent's access to school records? _____ Yes* ____ No
*If Yes, a copy of the order must be given to the school office.

Please provide any additional information regarding custody of which the school

should be aware: _____

_____

_____ _____
Date Signature of Custodial Parent

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Roster Card

One Call Now

Name: _____

Home ( ) _____

Cell ( ) _____

Office ( ) _____

Other ( ) _____

Please fill in and return. By returning this card, you give permission to receive calls.

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From the School Nurse:

No child may begin school without documentation of immunizations and a current physical within the last six months. The school nurse clears all students to begin school. Please call the school nurse at 973.293.7131 ext 214, to schedule an appointment to review immunization documents and health records.

Absence:

Your child is expected to be on time and in school every day that school is in session. If your child is sick and cannot attend school you must call the school nurse at 973.293.7131 ext 214, and report the child's name, grade, teacher, and reason for absence. When the child returns to school, a written reason of absence is needed. Please have doctor's notes given to the school.

Attendance:

Consistent attendance at school is a strong predictor of student achievement and success.

1. Children are expected to be in attendance every day school is in session.
2. Every absence from school will be documented and recorded.
3. If a child is in school less than four hours, the day is considered an absence.
4. Parents/guardians will be notified of their child's absences approximately every fifth day's absence.
5. Upon notification, parents/guardians will work to correct the absence pattern and may be required to meet with the Assistant Principal regarding attendance.
6. Parents/guardians of each absent child must call the nurse to explain the reason, or the school will call.
7. Two days after an absence a note must be brought to school explaining the cause, with a note from the doctor if that applies.
8. Any student absence without an acceptable note or at the accumulation of ten days will be considered truant. State mandates regarding truancy issues will be followed.
9. All absences are cumulative regardless of parent or physician notes.
10. If a child is ill and will be home longer than two days, parent may request the child's teacher prepare missed work after two day's absence.
11. After an absence of twenty days, retention is possible.
12. If school is required to close for extended periods, the legally required attendance of 180 days may lead to an extension of the school year, including attending on Saturdays or scheduled holidays.

Medication Policy:

It is the policy of the school board that all children's medication be administered by the parent whenever possible, If a child is required to take medication during school hours, the school nurse will administer the medication in compliance with the regulations that follow:

1. A prescription written by a physician stating child's name, diagnosis, name of medication, dosage, and time to be given.
2. This policy includes prescription and over-the-counter medications (i.e. Tylenol, Motrin, etc.)
3. Medication must be in a prescription labeled bottle.
4. Written permission signed by the parent.
5. The PARENT must deliver the medication to the school nurse.

NO medication will be dispensed without the physician and parent written authorizations.

MONTAGUE TOWNSHIP SCHOOL DISTRICT
SCHOOL YEAR: 2018-2019

MEDICAL HEALTH HISTORY AND EMERGENCY CONTACT FORM

Student Name _____ Grade & Teacher _____ DOB _____
Mailing Address _____ PO Box _____

Name *Address* *Telephone*

Mother/Guardian _____ Home _____ Home_____
Work _____Work_____
Cell _____

Father _____Home _____ Home _____
Work _____Work _____
Cell _____

Parent Email Address _____
Emergency Contact #1_____Phone _____
#2_____Phone _____

Does your child have health insurance?

Yes _____ *Name of Insurance Company or NJ FamilyCare Insurance Provider:* _____

*No*_____ *NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more info call* ***800-701-0710*** *or visit* ***www.njfamilycare.org*** *to apply online. You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.*

Signature _____ ***Date*** _____

MEDICAL HISTORY (Most recent)

Allergies: _____Plants_____Animals_____Food_____Mold_____Drugs_____Bees Date of reaction _____

Life threatening? _____Yes _____ No

There should be a meeting with the School Nurse to discuss medication or treatment orders.

Please describe the reaction & treatment _____

Documented Medical Condition & Restrictions if any: _____Date_____

Daily Medications & Dosages: _____Date_____

If your child needs to take medication at school, please download and print the form from the school website and have the doctor complete it. This form must be completed prior to the administration of any medication at school. The school nurse cannot give OTC (over the counter) medications without a doctor's note. An adult must bring to school any medication, including OTC meds to be given by the school nurse.

Recent Surgeries or Injuries _____ Date_____
Physical Exam Date_____ Doctor & Phone _____
Dental Exam Date_____ Dentist & Phone _____
Eye Examination Date _____

REMINDER

Please be advised that physicians recommend that a child have a physical examination at least once during each of the student's developmental stages: early childhood (preschool-grade 3), pre-adolescence (grades 4-6), and adolescence (grades 7-12). When your child receives a physical examination, please **submit a copy** of the report to the School Nurse so that your child's health history can be updated.

I am aware that my child will participate in the following School Health Services where applicable:

1. Vision & hearing screening
2. Scoliosis screening every 2 yrs starting at age 10
3. Height, weight & blood pressure
4. Periodic head lice checks

Have you ever been told by a physician or health care professional that your child has:

_____Asthma _____Seizure Disorder _____Bleeding Disorder _____ADD/ADHD
_____Diabetes _____Bone/Muscle Disorder _____Skin Condition
_____Heart Condition _____Mental Health Condition (i.e. depression, anxiety, eating disorder)
_____Learning Disability

Does your child experience any of the following:

_____Nose Bleeds _____Frequent Earaches _____Overweight for Age _____Underweight for age
_____Physical Disability ____Poor Appetite____Frequent Stomachaches ____Frequent Headaches
_____Fainting Spells _____Tires Easily _____Emotional concerns

Do any of the above condition(s) limit/effect your child at school? Yes_____ No_____

Describe _____

Hearing: Does your child wear hearing aids? _____Yes _____No

Vision: Does your child wear glasses or contacts? _____Yes _____Distance _____Reading

I understand that the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature _____ Date _____

MONTAGUE TOWNSHIP SCHOOL DISTRICT

Growth and Development

Registration _____
Date

_____ _____ _____ _____
Child's Last Name | First Name | Middle Name | Date of Birth

_____ _____
Address (Number, Street, Town) | Phone Number

_____
Mailing Address (if different than street address)

_____ _____ _____
Father's Name | Mother's Name | Last School Attended

Is your child subject to: (Please circle Yes or No) Has your child had:

Frequent Colds	Yes	No	Poor eating habits	Yes	No
Bronchitis	Yes	No	Eye Disease	Yes	No
Frequent sore throats	Yes	No	Head Injury	Yes	No
Speech Difficulties	Yes	No	A severe fall	Yes	No
Ear Aches	Yes	No	Difficulty sleeping	Yes	No
Development:			Eye Injury	Yes	No
Age Walked _____			Eyeglasses Prescribed	Yes	No
Age Talked _____			Hearing Loss	Yes	No

Has your child had a history of (Please circle and give dates)

Allergy:
Medication _____
Other _____
Chicken Pox
Enuresis (bed wetting)
Epilepsy
Heart Disease
Hepatitis
Hernia
High Fever
Hospitalization
Mononucleosis
Pneumonia
Tonsillitis
Tuberculosis
Whooping Cough

Operations:
Appendectomy: _____
Hernia Repair _____
Tonsillectomy _____
Ear Surgery _____
Other _____

Please list any childhood diseases, accidents or problems: _____

_____

_____

Medication: Please list medications your child takes both at home and in school. If your child must take prescription or over-the-counter medication (i.e. Tylenol, Motrin, etc) in school, a medical authorization form must be completed and signed by the parent/guardian and physician.

Please list my child and his/her health concern on your confidential list to be distributed to teachers and cafeteria staff ____ Yes ____ No

_____ _____
Parent/Guardian Signature | Date

MONTAGUE TOWNSHIP SCHOOL DISTRICT
475 Route 206, Montague, NJ 07827 * Phone (973) 293-7131 * Fax (973) 293-3391

School Year: 2018-2019

PHYSICAL EXAMINATION – To be completed by a medical doctor

Name _____ **DOB**_____ **Grade** _____

Height _____ **Weight** _____ **Blood Pressure** _____ **Pulse** _____

Significant Medical History: _____

_____

_____

Allergies: Insects Food Environmental _____

_____

Vision Screening _____ **Hearing Screening** _____

Examination Findings

Ears _____ **Abdomen** _____
Eyes _____ **Hernia** _____
Nose _____ **Scoliosis** _____
Throat _____ **Skin** _____
Heart _____ **General Appearance** _____
Lungs _____ **Neurological** _____
Other _____

Summary of Findings

_____

_____

Immunization History: M/D/YY (OR PLEASE ATTACH IMMUN. RECORD)

DPT	_____	**Trivalent Polio**	_____	**Measles**	_____
	_____		_____	**MMR**	_____
	_____		_____		_____
	_____		_____		
Booster	_____	**Booster**	_____	**Hepatitis B**	_____
Varicella	_____	**H.I.B.**	_____		_____
			_____		_____
			_____		

_____ _____

Physician Signature **Date of Exam**

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MEDICAL AUTHORIZATION FORM

TO BE COMPLETED BY PHYSICIAN

Student's Name_____ Age_____ Grade _____

Diagnosis _____

Medication _____

Dosage _____

Time of Administration _____

Possible Side Effects _____

Restrictions on Activities _____

_____ _____ _____
Physician's Name (Printed) Date Physician's Signature

TO BE COMPLETED BY PARENT

I request that my child _____ receive the medication prescribed by his/her physician. The medication is to be provided by me as required by School Board Policy. I understand that the district is rendering a service and does not assume any responsibility for this matter. I further understand that the school nurse, or substitute school nurse, will administer the medication.

NOTE: All medication, prescribed and over-the-counter, must be brought to the school by the parent, in the original, labeled bottle or container.

_____ _____
Parent/Guardian's Signature Date

MONTAGUE TOWNSHIP SCHOOL DISTRICT

REQUIRED IMMUNIZATIONS

DPT	**Diphtheria, Pertussis and Tetanus**: 4 vaccines with the 4th one being after the 4th birthday or any 5 vaccines
IVP	**Polio**: 3 vaccines with the 3rd one being after the 4th birthday or any 4 vaccines
HPT	**Hepatitis**: 3 vaccines (one usually at birth, the second vaccine one month later and the third one 5 months after the second one)
MMR	**Measles, Mumps and Rubella**: 2 vaccines (first one after the First birthday and the second one after the 4th birthday)
Varicella	**Chicken Pox**: 1 vaccine after the first birthday
Hib	**Influenza:** 4 vaccines before 18 months of age

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HOME LANGUAGE SURVEY*

Date: _____

School District: _____

School: _____ Grade: _____

Student's Name: _____

1. What was the student's first language? _____
2. Does the student speak a language other than English? ____ Yes ____ No

   If yes, specify language: _____
3. What language(s) is/are spoken in your home? _____
4. Has the student ever received English as a second language (ESL) services?
   ____ Yes _____No If yes, when?_____

   And from what school district?_____
5. Has your family ever received migrant services? ____ Yes ____ No

   If yes, please list the dates service was received: _____

   _____
6. Do either of the parents/guardians work in any field pertaining to agriculture?
   ____ Yes ____ No If yes, please specify where: _____

   _____

Person completing this form, if other than parent/guardian: _____

_____
Parent/Guardian Signature

* The school district/charter school has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school has the right to ask for the information it needs to identify English Language Learners (ELLs). AS part of the responsibility to locate and identify the ELL's, the school district/charter school may conduct screenings or ask for related information about students who are already enrolled in the district as well as from students who enrolled in the school district/charter school in the future.

****In summary, this form allows us to bill Medicaid for Speech, OT, PT, Counseling, School Nursing services, Transportation (if this applies) and IEP services. It DOES NOT give consent to speak to your physicians or outside services. It DOES NOT affect your benefits or cost to you at all. It DOES NOT sign you up for any type of insurance or Medicaid. It allows the school to get reimbursed for services, helping to generate income for the school system.

Medicaid Annual Notification
Regarding Parental Consent

Dear Montague Parents:

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).

The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.

In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent.

Is there a cost to you?
No. IEP services are provided to students while at school at NO cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program does not impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program does not affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?

- Evaluations
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- Specialized Transportation

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time by contacting the school in which your child is enrolled.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing,

What if you have questions?
Please call Tina Palecek, SEMI Coordinator at 973-293-7131 ext. 218 with questions or concerns, or to obtain a copy of the parental consent form.

Method of Delivery: (check one)____Mailed to parent(s)____Emailed to parent(s)____IEP meet_____Hand Delivered

Special Education Medicaid Initiative (SEMI) Parental Consent Form

Dear parents of Montague School:

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation), may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or insurance to pay for special education or related services under Part 300 (services under the IDEA).

I understand that billing for these services by the district **does not** impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: ——————————————————

Child's Date of Birth: —— —— ——————

Parent/Guardian: ——————————————————————————

Date:____/_____/_____

I give consent to bill for SEMI: Yes

No

This consent can be revoked at any time by contacting the administrator at your child's school.

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To: Parents/Guardians of Montague Students

Re: **Afternoon Bus Stops for KINDERGARTEN & ELEMENTARY students**

Students will be dropped off at their assigned bus stop **only if**:

1. The student is met by a parent or legal guardian, 18 years or older.

   OR

2. A written request designating a responsible person to meet the student at the stop has been submitted and approved by the transportation office.

If there is no parent or approved designated person to meet the student, the student will be returned to the school by the bus driver. At stops directly in front of a house, a long driveway, etc, there must be a visual contact of the parent or designated person by the bus driver or the student will be returned to the school.

Thank you for your cooperation.