
# MONTAGUE SCHOOL

## 2017 – 2018

## 1st – 8th Grade Registration Packet

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

Timothy C. Capone
*Chief School Administrator/Principal*

Tina M. Palecek
*Business Administrator/Bd. Secretary*

Donna Pinzone
*Administrative Assistant*

Christopher Gregory
*Assistant Principal*

## RESIDENCY REQUIREMENTS

**In order to have your son/daughter educated by the Montague Township School District, they and you as a parent or legal guardian must be full-time residents.**

**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.**

**By signing this form you are declaring that to the best of your knowledge the address you are supplying is within the Montague Township boundaries and you and the student you are registering are full-time residents at that address. 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 in an appropriate manner, and you will be directed to the proper school district, if known.**

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

**Thank you and welcome to the Montague Township School District.**

**Timothy C. Capone**
**Chief School Administrator/Principal**

**Signed:** _____
**Parent/Guardian**

**Address:** _____

_____

**Date:** _____

# Montague Township School District
# Montague School
# STUDENT REGISTRATION FORM

*Home of the Black Bears*

**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.

# Montague Township School District
# Montague School
# STUDENT REGISTRATION FORM

*Home of the Black Bears*

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. YMCA after school care will be notified of emergency dismissals. They will make calls to parents as well. YMCA 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: _____

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September 2017

TO: Parents/Guardians of Montague Students
SUBJECT: Afternoon Bus Stops

REMINDER:

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

1. **The student is met by a parent or legal guardian.**

   **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 not a 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.**

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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.**

## Please Note:

Only fill out one Roster Card per family.

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Former School Name _____
Address _____
Phone and Fax Number _____

Re: Student's Name _____ Date of Birth _____

Please forward all mandated records for the above-named student who has enrolled in the _____ grade of the Montague Township School, 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

# Montague School

475 Route 206
Montague NJ 07827

2017 ~ 2018
School Year

Student Name:

Student Homeroom:

Parent Name:

Parent email address:

The above is my correct email: Yes _____ No ____

If there is no email indicated above, or if your email is wrong, please enter your email address in the boxes below. For accuracy, please print legibly and one letter per box. If you are using the number zero (0) indicate by putting a slash through it.

| | | | | | | | | | | | | | | @ | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

oncourse
SYSTEMS FOR EDUCATION

You are being given a username and password to access the Oncourse Parent Portal. You will only be given this code once. If you forget your username, you must contact the Central Office to request a reprinted copy. If you forget your password, there is a link on the parent portal to reset your password.

The letter includes directions on how to log on. If you have more than one child in this school, they will all be accessible with the one username.

Please sign and date below.

Sign: _____ 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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**The Parents/Guardians of _____ class _____**

**PERMISSION TO PUBLISH**

## **Publishing Student's Name

I understand that my child's name may be published in newsletters, newspapers or magazines or on the school website.

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

***Parent/Guardian's Signature_____ Date_____***

## **Publishing Student Work

I understand that my child's artwork or writing may be published in newspapers or magazines or on the World Wide Web, a part of the Internet, as part of classwork. I understand that copyright and ownership of the work or writing remain my child's property. I grant permission for this publishing as described. A copy of all such publishing will be printed out and brought home for me to see upon request.

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

***Parent/Guardian's Signature_____ Date_____***

## **Publishing Student Image

I understand that my child's image may be published in newspapers or magazines or on the World Wide Web, a part of the Internet, as part of classwork. No last name, home address, telephone number or email address will appear with such images.

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

***Parent/Guardian's Signature_____ Date_____***

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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 then 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 SCHOOL

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

475 Route 206 Montague, NJ 07827 Phone 973.293.7131
Rev 08/15 Fax: 973.293.3391

# MONTAGUE SCHOOL

**School Year: 2017-2018**

# 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** _____

# **Immunizations required to begin Kindergarten**:

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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# MEDICAL AUTHORIZATION

**TO BE COMPLETED BY PHYSICIAN**

Students Name_____ Age_____ Grade _____

Diagnosis _____

Medication _____

Dosage _____

Time of Administration _____

Possible Side Effects _____

Restrictions on Activities _____

_____ _____ _____
Physicians Name (Printed) Date Physicians 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 Signature Date

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

**School Year: 2017-2018**

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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# 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.

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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

****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.