Convenient Parent Check Off List:

As you are completing the needed enrollment forms, feel free to use this convenient check off list to make sure you have completed and submitted all of the required forms.

________ Physical

________ Immunization Record

________ Breakfast Waiver

________ Parent Agreement for Child Care

________ Authorized Pick-Up Form

________ Emergency Information Sheet

________ MSDWT Student Registration/Emergency/Health

________ Photo Permission Form

________ Copy of Birth Certificate

________ "Getting to Know your Child" Questionnaire

________ Record of Medication Order (Optional)

________ Payment Contract (contact Charlotte Watson thru Business Office)

________ Enrollment Contract (contact Charlotte Watson thru Business Office)

________ Criminal History Check (for volunteering in classroom – optional)

________ Activity Fee $30 per semester (checks made out to JELCC)

HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
CHILD CARE CENTER HEALTH RECORD

State Form 49969 (R4 / 2-15)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W361
INDIANAPOLIS, IN 46204

Name of child (*last, first*)	Date of birth (*month, day, year*)	Date of admission (*month, day, year*)

Address (*number and street, city, state, and ZIP code*)

Child lives with (*relationship*)	Name	Telephone number
		( )

MEDICAL HISTORY

Communicable Disease	Month / Year	Condition	Explain if present
		Allergies:	
		Handicapping conditions:	
Screenings	**Result / Date** (*month, day, year*)		
TB Risk / Symptom		Other:	
Developmental Screen			
Lead			

PHYSICAL EXAMINATION

Date of exam (*month, day, year*)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (*including sports*)?

☐ Yes ☐ No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

☐ Yes ☐ No

(Over)

HISTORY OF IMMUNIZATIONS AND TEST (*indicate month / day / year*)

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* Influenza (Flu)					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
Rotavirus (RGE)			

	1	2
Varicella (Varivax)		

or Chicken Pox Disease

Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEP A		

	1	2	3
HBV (HEP B)			

* Recommended yearly.

Name of physician / nurse practitioner completing form (*please print*)	Telephone number ( )
Signature of physician / nurse practitioner	

ADDITIONAL NOTES AND INSTRUCTIONS

J. Everett Light Child Care Center

1901 East 86th Street

Indianapolis, IN 46240

BREAKFAST WAIVER FORM

I, ____________________________ parent(s) or guardians of ______________________________

agree to serve my child breakfast before bringing him/her to the child care center. I understand that based upon Family and Social Services regulation requirements, my child may not bring food into the center. I agree that I will see that my child will be fed before arriving at the center. I further understand that a light breakfast consisting of fruit or juice, a bread product and milk will be offered at 6:45 am for an additional $1.25 per day charge.

Parent(s) Signatures: ______________________________ ________________________________

Date: _________________________________

J. Everett Light Career Center
Child Care Center
1901 East 86th Street
Indianapolis, IN 46240

PARENT AGREEMENT FOR CHILD CARE

I wish to enroll ______________________________ Age: ______________
Birthday: ______________________ at J. Everett Light Child Care Center beginning
______________________.

I AGREE TO THE FOLLOWING POLICIES:

I understand that my child must have reached his/her third birthday by the start of school and may stay in the program until he/she is six. However a formal kindergarten program will not be offered.

I understand that the curriculum will be based on weekly themes. Teachers will create developmentally appropriate lesson plans using various themes. Activities will include but are not limited to art, math, music, science, social studies, and gross motor.

I understand that my child must have self-toileting skills, unless there is a medical reason preventing it, before being accepted into the program.

I understand that my child must get a complete physical. The health Record **MUST** be completed prior to the first day that my child attends the program. It may be completed up to twelve months prior to the start of school. All immunizations must be accurately recorded on the form provided. The doctor or nurse practitioner must sign the form.

I understand that a copy of my child's birth certificate is to be on file at the center prior to the start of school.

I agree to fill out an emergency form to be kept on file in the Child Care Center Office.

I understand that parents will be asked to sign a Breakfast Waiver Form.

I agree to read and be aware of the discipline policy of the Center

The Child Care tuition will be paid in advance and in full each month. The tuition payment is due the first school day of each month and must be paid by Friday of that week. The fee must be paid via the on-line payment system. Payments other than the activity fee will not be accepted at the preschool due to security reasons.

I understand that my child will be withdrawn from the program with a week's notice if fees are more than four days delinquent.

The Child Care tuition is $ 777.00 per month. Fees have been adjusted for holidays and all other school closings.

I understand that there will be a $30 per semester activity fee. The fee cannot be combined with other payments. The activity fee can be paid for the year at the beginning of the first semester.

I understand that the hours for the child care center will be 6:30 am – 6:00 pm.

I understand that a "late fee" will be charged if I pick up my child after 6:00 pm regardless of the nature of the delay. The late fee is $1 per minute.

I understand if I am consistently late I will be asked to remove my child from the program.

I will see my child safely to a teacher before leaving him/her and I will speak with a teacher before taking my child from the center.

I understand that I am expected to pick up my child within the prescribed times unless there is a delay or emergency, in which case the Center must be notified immediately

I will give written permission to the Center for a responsible person to escort my child to and from the Center in my absence if necessary.

I will notify the teacher immediately if my child has been exposed to a contagious disease or has been ill.

I authorize the teacher to secure medical treatment if my child becomes ill or has an accident while at the Center.

I understand that any medication to be administered by the Center must be accompanied by a Doctor's Instructions for dosage. This applies to all medications – prescriptions, over the counter medications, and doctor's samples.

I understand that if my child is ill upon arrival, he/she will not be admitted to the classroom.

I understand that the children will go outside for a period of time every day when the temperature, including the wind chill factor is 25 degrees or higher. Children if properly clothed (hat, coat, mittens, boots etc.) will not get sick from being outside for a brief period of time during winter months.

I will inform the Center immediately of any change of address, telephone number, place of employment, or marital status affecting the child's custody.

I agree that my child will participate in activities supervised by high school students who are enrolled in the Early Childhood Program through the J. Everett Light Career Center.

I understand that any food brought into the Center must be store bought, commercially packaged and unopened. Homemade treats are not accepted.

I give permission for my child to go on field trips.

I give permission to use my child's name and for him/her to be photographed or interviewed by local school media connection with agency publicity.

I understand that if my child cannot adjust to the program because of social, physical, or emotional problems after a reasonable trial period and appropriate conferences, I will be asked to remove my child from the program.

I have read the parent manual and agree to abide by all guidelines.

______________________	______________________
Parent/Guardian Signature	**Date Signed**
______________________	______________________
Parent/Guardian Signature	**Date Signed**

The following individuals are authorized to pick up my child:

Name	Relationship	Address	Telephone #
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

The following individuals are NOT under any circumstances allowed to pick up my child(ren) at any time:

1. ______________________________

2. ______________________________

______________________________ Parent Signature

______________________________ Date

______________________________ Parent Signature

______________________________ Date

Emergency Information Sheet

Child's Name ____

Address ____

Telephone Number (s) ____________________ ____________________

Parent(s) Name:	Place of Employment	Business Telephone Number

List two relatives or people who will assume temporary care of your child if you cannot be reached.

1. Name:	Relationship:
Address:	Telephone:
2. Name:	Relationship:
Address:	Telephone:

Hospital Preferred by family: ____

Child's Physician ____________________________ Telephone ____________________

Family Dentist ____________________________ Telephone ____________________

My child has the following special medical conditions: (Check all that apply)

____ Convulsions ____ Heart ____Asthma ____ Allergies ____ Diabetes ____ Visually Impaired ____ Hearing Impaired ____ Physical Disabilities ____ Other (Please list below)

____

If my child is injured or becomes seriously ill and none of the above people can be reached by telephone, I hereby give permission to the school authorities to render judgment in transporting my child to a hospital for any treatment deemed necessary by your physician or by other available physicians. As parent, I will assume all financial responsibility in such an emergency.

Parent Signature: ____

MSD OF WASHINGTON TOWNSHIP
STUDENT REGISTRATION/Emergency/Health

Student ID:________________ Grade________
School________________ Date________
Homeroom Teacher________________

INSTRUCTIONS: The Registration form is a required official record. The questions on this form ask for important information that will help provide services for your child. If any information you provide should change in the future, please notify your school immediately. **Please print, complete all information and sign the last page.**

STUDENT NAME

LAST:________________
FIRST:________________
MIDDLE:________________
DATE OF BIRTH:________________
PRIMARY PHONE #________________

STUDENT ADDRESS

STREET:________________
APT#:________________
CITY:________________ ZIP:________
GENDER: ☐FEMALE ☐MALE

STUDENT LIVES WITH: ☐BOTH PARENTS ☐MOTHER ONLY ☐MOTHER/STEPFATHER ☐LEGAL GUARDIAN ☐GRANDPARENTS ☐FATHER ONLY ☐FATHER/STEPMOTHER ☐FOSTER PARENT

LIST SIBLING(S):

NAME	GRADE	SCHOOL	NAME	GRADE	SCHOOL

Life-Threatening Allergies / Serious Medical condition — Initials of Registrar ________

Student has a Life-threatening Allergy (be specific):________________

Student has a serious medical condition (be specific):________________

Your child can't start school until a medical alert conference is held. This meeting will be scheduled as soon as possible and by no later than three school days after the day of registration.

PARENT/GUARDIAN INFORMATION

RELATIONSHIP TO STUDENT:________________ PRIMARY PHONE #________________
LAST NAME:________________ WORK PHONE #:________________
FIRST NAME:________________ CELL PHONE #:________________
(COMPLETE IF DIFFERENT FROM STUDENT)
ADDRESS:________________
E-MAIL ADDRESS:________________

- - - - - - - - - - - - - - - - - - - -

RELATIONSHIP TO STUDENT:________________ PRIMARY PHONE #________________
LAST NAME:________________ WORK PHONE #:________________
FIRST NAME:________________ CELL PHONE #:________________
(COMPLETE IF DIFFERENT FROM STUDENT)
ADDRESS:________________
E-MAIL ADDRESS:________________

EMERGENCY CONTACT INFORMATION

LIST TWO ADULTS WHO MAY PICK UP AND CARE FOR YOUR CHILD IN CASE OF ILLNESS OR EMERGENCY AND YOU CANNOT BE CONTACTED. IF NO ONE CAN BE REACHED IN AN EMERGENCY, 911 WILL BE CALLED.

1. NAME:________________ 2. NAME________________
PHONE #:________________ PHONE #:________________
RELATIONSHIP TO STUDENT:________________ RELATIONSHIP TO STUDENT:________________
ADDRESS:________________ ADDRESS:________________

- - - - - - - - - - - - - - - - - - - -

PHYSICIAN/DOCTOR:________________ ADDRESS:________________ PHONE:________
DENTIST:________________ ADDRESS:________________ PHONE________
IN CASE OF EMERGENCY PREFERRED HOSPITAL:________________

MSD OF WASHINGTON TOWNSHIP SCHOOL HEALTH SERVICES – STUDENT HEALTHY HISTORY

In order for us to assist your child in gaining the most from his/her school experience, it is necessary to have a current health history.

Has your child ever had or does he/she have now? (Please check at right of each item)

	Yes	No	Year/Description
Allergies			
Food			
Medication			
Bee sting			
Other			
Injuries – concussion – head injury			
Frequent or excessive nose bleeds			
Hospitalizations - operations			
Orthopedic – bone or joint - problems			
Asthma			
Diabetes			
Sickle Cell Anemia			
Anemia			
Hearing loss - use of hearing aids			
Vision loss – wears contacts/glasses			
Speech condition			
Dizziness, fainting, severe or frequent headaches			
Epilepsy – seizures or convulsions			
Heart conditions			
Contact with tuberculosis/positive tuberculin skin test			
Severe abdominal pain – ulcer			
Excessive ear infections			
Excessive colds			
Frequent or painful urination			
Intestinal condition			
Family history of scoliosis			
Excessive worry, anxiety, or depression			

LIST ANY MEDICATION(S) YOUR CHILD TAKES REGULARLY:

____

IS THERE ANY OTHER INFORMATION THAT MIGHT BE HELPFUL FOR US TO KNOW ABOUT YOUR CHILD OR CIRCUMSTANCES AT HOME THAT COULD AFFECT HIM/HER AT SCHOOL?____

HEALTH CONSENT

I hereby give consent for my minor child to receive necessary health services from the designated Health personnel or other designated District personnel in our schools when he/she becomes ill or injured during the school day. I understand that treatment by District or Health personnel is limited to first aid care for injuries occurring at school, illness, health screens in conjunction with the Marion County Health Department and the administration of previously authorized medication. I understand that injuries incurred elsewhere, other than at school, must be cared for at home or by a personal health care provider.

I hereby give permission for the above information to be shared with appropriate staff and emergency personnel in a confidential manner under the provisions of the Family Education Rights and Privacy Act (FERPA). I understand that FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances.

I hereby authorize the MSD of Washington Township to release my child's immunization record to the Indiana State Department of Health's Children and Hoosier Immunization Registry Program (CHIRP). I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my eligible child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

______________________________ ______________

PARENT/GUARDIAN SIGNATURE **DATE**

TRANSPORTATION, FIELD TRIP AND MEDIA PERMISSION

YES NO

_____ _____ **I have discussed the bus rules with my child. I understand that violations of the rules will result in disciplinary consequences.**

_____ _____ **I give permission for my child to participate on field trips for this school year. I understand the information supplied and agree to inform the classroom teacher in the event that my child is <u>not</u> to participate in the specific field trip.**

_____ _____ **I give permission for my student's name or picture to be used for media release.**

______________________________ ______________

PARENT/GUARDIAN SIGNATURE **DATE**

8550 Woodfield Crossing Blvd. • Indianapolis, Indiana 46240 • P: 317-845-9400 • F: 317-205-3385 • www.msdwt.k12.in.us

Metropolitan School District of

WASHINGTON TOWNSHIP

"Superior Schools in a Supportive Community"

Dear Parents,

Throughout the school year we like to take pictures of our classrooms and the children participating in a variety of activities during the day.

At times, we like to display these photos to show all of the good work that is going on at the preschool.

Currently, we are creating a link on the JEL website, so again we have an opportunity to showcase our program and the children hard at work.

In order for us to have your child's photo on display we need your permission. No names are ever used, just pictures, which could be both individual and or group.

Please complete and return the form below so that we can adhere to your desires in this area.

____YES, I give permission for my child's photo to appear in school displays and on the website.

____NO, I do not wish to have my child's photo on display.

Child's Name____

Parent Signature____

Thank you, and watch the website for good information and fun pictures.

J. Everett Light Staff

J. Everett Light Career Center
Child Care Program Payment Authorization
Agreement

Parent #1
Name:____________________
Address:____________________
Zip Code________ Phone____________
MSD Employee? Yes No Location:______

Parent #2
Name:____________________
Address:____________________
Zip Code________ Phone____________
MSD Employee? Yes No Location:______

Child 1:____________________ Age: __________
Child 2:____________________ Age: __________
Child 3:____________________ Age: __________

Parent Responsible for Payment____________________ SSN __________

The JEL Career Center Child Care Payment is $7,777.00 annually per child to be paid in 10 monthly installments. There is a non-refundable deposit of $777.00 that will be applied towards your first monthly payment. The deposit is to be paid in full no later than May 25, 2018 to reserve your child's spot for the 2018-2019 school year. The schedule below illustrates how the monthly payments will be deducted from your designated account on file. ($42.00 per day times 185 days = $7,777.00)

#	Date	Amount	#	Date	Amount
1	Prior to May 25	$777.00	6	January 1, 2018	$777.00
2	September 1, 2018	$777.00	7	February 1, 2019	$777.00
3	October 1, 2018	$777.00	8	March 1, 2019	$777.00
4	November 1, 2018	$777.00	9	April 1, 2019	$777.00
5	December 1, 2018	$777.00	10	May 1, 2019	$777.00
				Total Payment:	**$7,777.00**

I authorize MSD Washington Township to charge my designated bank account/credit card for the monthly amount of $777.00 per child in accordance with the dates listed in the aforementioned section. If my payment is returned due to insufficient funds and/or closed account, I understand the district will charge an additional fee of $25.00 per occurrence. I will notify MSDWT's Business Office of any account changes that will affect my monthly payment from being charged on the payment date. My initial deposit will be charged against my bank account/credit card within 10 business days of the district receiving this authorization form.

Type of Account: (Please circle one) MasterCard Visa Checking Account
Name as it appears on card/checking account:____________________
Address:____________________
City, State ,Zip:____________________
Cell Phone:____________________
Email Address:____________________
If Using a Credit Card:
Expiration Date____________ 3 digit security code:____________
Credit Card # ____________________
If using a Checking Account, Please Include a Voided Check for Accuracy.
Bank Name: ____________________
Routing Number: (9 digit # usually beginning with 074 or 274)____________________
Account # ____________________
Signature:____________________ Date: ____________

Internal Use Only
Date Received: ____________ Date Processed: ____________
Received by: ____________ Processed by: ____________

MSD WASHINGTON TOWNSHIP
J. Everett Light Child Care Program Tuition
2018-2019 Enrollment Contract

Child's Name:

Parent/Guardian Information

Parent/Guardian's Name:____
Home Phone:____________________ Work Phone:______________________________
Email:__________________________ Cell Phone: ______________________________
Street Address:______________________ City: _______________________ Zip: ______________
Date of Birth:_____________________ SSN: __________________
Employer: ____

Please Choose One of the following Payment Options
ALL PAYMENTS ARE REQUIRED TO BE MADE THROUGH AN E-FUNDS ACCOUNT

Tuition Options

________**Option 1:** Pay the non-refundable retaining fee of $777.00 by May 25, 2018. This payment covers the tuition for the month of August. The remaining 18 payments will be paid in two week increments of $388.50 from September through May (this payment covers the remainder of the tuition from 09/01/18 – 05/23/19) using an electronic check, debit or credit card payment set up in e-funds ONLY.

________**Option 2:** Pay the non-refundable retaining fee of $777.00 by May 25, 2018. This payment covers the tuition for the month of August. The remaining balance will be charged to your e-fund account in 9 equal monthly payments of $777.00, beginning 09/01/18 – 05/01/19) using an electronic check, debit or credit card payment set up in e-funds ONLY.

Meal Options:

________**Option A:** I understand that based upon Family Social Services regulations requirements, my child may not bring food to the Childcare Center. Therefore, I will see that my child will be fed before arriving at the Center.

________**Option B:** I understand that based upon Family Social Services regulations requirements, my child may not bring food to the Childcare Center. MSD Washington Township will provide my child a light breakfast consisting of fruit, a bread product, and milk at 6:45 a.m. each day for an additional $120.00 a semester.

*All signed forms must be turned in prior to children attending child care.
* I understand that the $777.00 holds a place for my child in the J. Everett Light Childcare Program for 2018-2019 and is NON-REFUNDABLE.
* I understand that if tuition is not paid according to the terms of the option I have chosen, my child may be withdrawn from the Program.

____

Signature/Parent or Guardian Date

Getting To Know Your Child

Parents:

It is our goal to make your child's experience in the preschool as successful as possible. We believe that parents are the first teachers in the child's life. One of our goals is to build partnerships with our children's families. Please take the time to complete this packet. This information will help us get to know your child. It will help us in our planning process and with positive interactions with your child.

Child's Name: ______________________________

Age: __________ Birthdate: ____________________

Child's Favorites:

Color: ____________________ Game: ____________________

Food: ____________________ Character: ____________________

Toy: ____________________ Alone Activity: ________________

Story: ____________________ Group Activity: ________________

Song: ____________________

My child has the following pets: ____________, ____________, ____________

My child has _____ brothers and _____ sisters

Their names are: Their ages are:

____________________ ______

____________________ ______

____________________ ______

____________________ ______

Turn over

Describe your child's cognitive, physical and social development (i.e. ability to interact with other children, ability to share, response to adults requests); recognition of colors and shapes; the ability to count; experience with art materials, ability to dress themselves, self-toileting skills, fine motor skills, gross motor skills).

In reference to the above question, state any limitations or lack of experience in each area.

Continue

Please provide any additional information that will help us make your child's experience with us successful.

8550 Woodfield Crossing Blvd. • Indianapolis, Indiana 46240 • P: 317-845-9400 • F: 317-205-3385 • www.msdwt.k12.in.us

Metropolitan School District of
WASHINGTON TOWNSHIP
"Superior Schools in a Supportive Community"

Nikki C. Woodson, Ph.D., Superintendent

Volunteer Form – Expanded Criminal History Record Check (Form 8120B)

Dear Volunteer:

Thank you very much for your willingness to assist in the education of our children of the MSDWT. A strong base of volunteers is essential to provide the necessary supports to students' academic, social, and emotional development. While we welcome volunteers into our school community, we must also be diligent in providing a safe and secure environment for our students. To that end, the Board of Education of the Metropolitan School District of Washington Township policy states in part:

8120 – VOLUNTEERS

The Board of Education recognizes that certain programs and activities can be enhanced through the use of volunteers who have particular knowledge or skills that will be helpful to members of the staff responsible for the conduct of those programs and activities.

The Superintendent shall be responsible for recruiting community volunteers, reviewing their capabilities, and making appropriate placements. The Superintendent shall not be obligated to make use of volunteers whose abilities are not in accord with Corporation needs.

Each volunteer who is or expected to be in direct contact with students will be required to submit a Limited Criminal History Record Check.

The procedures shall ensure that information and records obtained from criminal history inquiries under this policy are confidential and shall not be released except as necessary to implement this policy or to defend a decision made pursuant to this policy.

The Superintendent is to inform each volunteer that s/he:

A. *shall agree to abide by all Board policies and Corporation guidelines while on duty as a volunteer;*
B. *will be covered under the Corporation's liability policy but the Corporation shall not provide any type of health insurance to cover illness or accident incurred while serving as a volunteer, nor is the volunteer eligible for workers' compensation;*
C. *will be asked to sign a form releasing the Corporation of any obligation should the volunteer become ill or receive an injury as a result of his/her volunteer services;*
D. *will be required to report any personal arrests or the filing of criminal charges while serving as a volunteer.*

Expanded Volunteer Role Requirements

Volunteers are often placed in a role that includes a heightened level of supervision and responsibility.
Each volunteer who could have sole care, custody, or control of students or may provide supervision of students during overnight events (either offsite or on school grounds) will be required to:

- ✓ Complete an Expanded Criminal History Record Check, which may include a sex offender registry check.
- ✓ Complete the mandatory bullying prevention training.

Expanded Criminal History Record Check

To access the mandatory Expanded Criminal History Record Check, follow these instructions:

1. Visit the MSDWT website: http://www.msdwt.k12.in.us/
2. Under the "Human Resources" menu, select "Prospective Employees".
3. Click the "Safe Hiring Background Check" button.
4. Provide your name and email address. Click the "Login" button.
5. Click on the empty drop-down box. Select "VOLUNTEER".
6. Continue by following the remaining directions on the page. Click the "Submit" button when finished.

Please note that you will need a debit or credit card to complete this process. All background checks are non-refundable.

The Expanded Criminal History Record Check for volunteers will include the same search criterion which is applied to prospective MSDWT employees. This check does require a fee and the cost is the responsibility of the volunteer applicant or the organization representing the volunteer applicant.

The Expanded Criminal History Check shall include but not be limited to:

A. national criminal history check (as defined by I.C. 20-26-2-1.5) of the criminal history record system maintained by the Federal Bureau of Investigation based on fingerprint identification or another method of positive identification;
B. search of the national sex offender registry maintained by the United States Department of Justice;
C. an Indiana Bureau of Motor Vehicles driver history if the position involves driving.

All information regarding the applicant will remain confidential.

The requested information meets the minimum requirements of the State of Indiana.

Bullying Education and Training Requirement

Indiana Code 20-26-5-34.2 states that a school corporation must provide bullying education and training to all employees and volunteers that have a direct, ongoing contact with students. If your volunteering duties require direct contact with an individual student or groups of students, or if you may be placed in a role that requires you to supervise or oversee students in any capacity, you are responsible for the completion of the bullying education and training provided by the MSDWT.

The link to the bullying education and training may be accessed by clicking on or typing the following link into your web browser.

https://msdwt-in.safeschools.com/register/84afcb3f

MSDWT Board Policy 8750 – Defense and Indemnification of Board Members and Employees, provides volunteers with legal defense in the case of a legal claim against the volunteer while acting in good faith on behalf of MSDWT students as long as there has been no neglect, omissions, act of bad faith, or act of malfeasance on the part of the volunteer.

By signing below, you are acknowledging:

- You understand your responsibility to complete the bullying education and training provided by the MSDWT when your role as a volunteer meets the criteria stated above, and;
- The bullying education and training must be completed annually, and;
- You understand, should you fail to complete the training and you are the subject of a claim while volunteering in the MSDWT, the MSDWT will consider your failure to complete the course as an act of omission and bad faith and will not be considered as eligible for a determination of whether or not to defend or indemnify you in any legal proceeding.

PLEASE SUBMIT ONE FORM PER PERSON AND PRINT LEGIBLY

Legal Name: ____
(Please Print) (Maiden Name/Other Name)

Sex: ☐ Male ☐ Female

Date of Birth: ____

Race: ____

Student Name(s): ____
(If Applicable)

Teacher Name(s): ____
(If Applicable)

Check the school(s) where you will be volunteering:

☐ **Allisonville** ☐ **Crooked Creek** ☐ **Fox Hill** ☐ **Greenbriar** ☐ **John Strange** ☐ **Nora** ☐ **Spring Mill**

☐ **Eastwood** ☐ **Northview** ☐ **Westlane** ☐ **North Central** ☐ **J. Everett Light** ☐ **Hilltop**

Signature: ______________________________ **Date:** ______________

If you have questions, please call (317) 845-9400.