DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT
Students Rise. We All Rise.

Enrollment Form

School: _____ **Date:** _____

REQUIRED DOCUMENTS

The following documents are required in addition to the completed and signed enrollment form. They should be provided before the child's first day of school but must be submitted no later than 30 days from the first day.

- ☐ Parent/Guardian photo ID
- ☐ Student's birth certificate or birth record
- ☐ Student's immunization record or waiver
- ☐ Student's most recent transcript or report cards
- ☐ Two forms of proof of address, such as: Driver's license, Detroit ID, W-2, public assistance documents, pay stub, official government mail, utility bill, etc.

*Some families may qualify for support with obtaining documents.

STUDENT INFORMATION

First Name:	Middle Name:	Last Name:	Suffix (Jr., III, etc.)

Date of Birth: (MM/DD/YYYY)	Preferred Gender: ☐ Female ☐ Male
Primary Parent Phone *(if applicable)*: ( )	Primary Parent Email *(if applicable)*:

Grade Entering:	School Year:	Is the student a member of multiple births? ☐ Yes ☐ No

Student's Physical Address:

Street:	Apt #:

City:	State:	ZIP Code:

Mailing Address (if different from Physical Address)

Street:	Apt #:

City:	State:	ZIP Code:

What country was the student born in?	If any country other than U.S.A., please answer the following two questions: What year did the student arrive in the U.S.A.? _____ (YYYY) When did the student first enroll in a U.S. school? _____ (MM/DD/YYYY)

Does the student have an Individualized Education Plan (IEP)? ☐ Yes ☐ No

Does the student have a 504 Plan? ☐ Yes ☐ No

If you answered "Yes" to any of the above, please provide a copy of your special education document(s) with your enrollment packet.

Has the student or family moved in the past three years looking for temporary or seasonal employment in agriculture or fishing?

☐ Yes ☐ No

STUDENT LANGUAGE

Student's native language? ❑ English ❑ Other_____

Is a language other than English spoken in the home? ❑ No ❑ Yes: language spoken _____

Has student ever been enrolled in a Bilingual, English Language Learner, or Newcomer program? ❑ Yes ❑ No

STUDENT RESIDENCY

The following questions are given to all students to ensure our district remains in compliance with federal law. Your answers will help school staff to determine if the student is eligible for certain support services.

Does the student live with his/her biological parent(s)?

❑ Yes ❑ No

Does the student live in any of the following types of residences?

- ❑ Shelter
- ❑ Transitional Housing
- ❑ Doubled Up/Shared housing with family, friends or others
- ❑ Hotel or motel
- ❑ Unsheltered (Such as: Campground, Car, Park, Abandoned Building, Substandard Housing, Bus or Train Station, etc.)

If you answer "no" to the first question OR have checked any of the residences listed above, please complete the McKinney Vento Student Referral Form at bit.ly/External-DPSCD.

FOSTER CARE

Is the student in Foster Care?

❑ Yes ❑ No

If so please provide the case worker's contact information:

Name: _____

Phone : _____

Email: _____

STUDENT ETHNICITY

SELECT ALL THAT APPLY

If you do not choose an answer, the U.S. Dept. of Education requires the District to supply answer on your behalf.

Student's Race *(select all that apply):*

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latinx
- ❑ White (Select one)
  - ❑ European
  - ❑ Middle Eastern
  - ❑ North African
- ❑ Native Hawaiian/Other Pacific Islander

PREVIOUS SCHOOL INFORMATION

School student most recently attended

Name:

City/State:

Student ID Number *(current DPSCD students)*

INFORMATION OF PARENT / GUARDIAN 1

First Name:	Last Name:	Relationship to Student:
Cell Phone: ( )		Home Phone: ( )
Work Phone *(if applicable)*: ( )		Email:

Same address as student's physical address? ❑ **Yes** ❑ **No, provide address:**

Street:	Apt #:

City:	State:	ZIP Code:

Does the parent/guardian require communication from the school in a language other than English?

❑ No ❑ Yes, what language? Written _____ Spoken _____

Is the parent/legal guardian currently serving in any branch of the Army, Navy, Air Force, Marines, or Coast Guard? This includes the Michigan National Guard or Reserve personnel. ❑ **Yes** ❑ **No**

INFORMATION OF PARENT / GUARDIAN 2

First Name:	Last Name:	Relationship to Student:
Cell Phone: ( )	Home Phone: ( )	
Work Phone *(if applicable)*: ( )	Email:	

Same address as student's physical address? ❑ **Yes** ❑ **No, provide address:**

Street:	Apt #:

City:	State:	ZIP Code:

Does the parent/guardian require communication from the school in a language other than English?

❑ No ❑ Yes, what language? Written _____ Spoken _____

Is the parent/legal guardian currently serving in any branch of the Army, Navy, Air Force, Marines, or Coast Guard? This includes the Michigan National Guard or Reserve personnel. ❑ **Yes** ❑ **No**

INFORMATION OF PARENT / GUARDIAN 3

First Name:	Last Name:	Relationship to Student:
Cell Phone: ( )	Home Phone: ( )	
Work Phone *(if applicable)*: ( )	Email:	

Same address as student's physical address? ❑ **Yes** ❑ **No, provide address:**

Street:	Apt #:

City:	State:	ZIP Code:

Does the parent/guardian require communication from the school in a language other than English?

❑ No ❑ Yes, what language? Written _____ Spoken _____

Is the parent/legal guardian currently serving in any branch of the Army, Navy, Air Force, Marines, or Coast Guard? This includes the Michigan National Guard or Reserve personnel. ❑ **Yes** ❑ **No**

INFORMATION OF PARENT / GUARDIAN 4

First Name:	Last Name:	Relationship to Student:
Cell Phone: ( )	Home Phone: ( )	
Work Phone *(if applicable)*: ( )	Email:	

Same address as student's physical address? ❑ **Yes** ❑ **No, provide address:**

Street:	Apt #:

City:	State:	ZIP Code:

Does the parent/guardian require communication from the school in a language other than English?

❑ No ❑ Yes, what language? Written _____ Spoken _____

Is the parent/legal guardian currently serving in any branch of the Army, Navy, Air Force, Marines, or Coast Guard? This includes the Michigan National Guard or Reserve personnel. ❑ **Yes** ❑ **No**

SIBLINGS AT TENDING DPSCD SCHOOLS

First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)
Relationship to Student:	School Attending:	Grade:
First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)
Relationship to Student:	School Attending:	Grade:
First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)
Relationship to Student:	School Attending:	Grade:
First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)
Relationship to Student:	School Attending:	Grade:
First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)
Relationship to Student:	School Attending:	Grade:

MASS COMMUNICATIONS

Detroit Public Schools Community District uses mass communication tools including phone calls, emails or text messages to notify families about school closures, important news and events.

ACKNOWLEDGMENTS & SIGNATURE

I certify that the information provided on this Enrollment Form is true and correct. If necessary, I will allow an interview by the District to verify. I understand that incorrect information may be grounds for revoking enrollment. I understand that it is my responsibility to inform the appropriate school office if/when there is a change to any information on this form.

By signing this Enrollment Form, I accept and agree that if any statements and information used to determine residency are not accurate, I will be personally liable to pay to the District tuition and any fees incurred to collect tuition for all periods of time my student was a non-resident.

_____	_____	_____
Parent or Guardian Signature	Print Name	Date (MM/DD/YYYY)

DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT

DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT
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District Emergency Contact and Medical Authorization Form

School: _____ **School Year:** _____

STUDENT INFORMATION

First Name:	Last Name:	Date of Birth: (MM/DD/YYYY)
Grade:	Homeroom Teacher:	Homeroom Classroom Number:
Home Address Street:	City:	ZIP Code:
Student Cell Phone: ( )	Student Email:	

Who does the student live with? Select all that apply:

❑ Mother ❑ Father ❑ Guardian ❑ Grandparent ❑ Other Relative ❑ Other _____

EMERGENCY CONTACTS INFORMATION

PRIMARY CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Step Parent ❑ Legal Guardian ❑ Other _____

SECONDARY CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Step Parent ❑ Legal Guardian ❑ Other _____

ADDITIONAL CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Step Parent ❑ Legal Guardian ❑ Other _____

EMERGENCY CONTACTS INFORMATION - CONTINUED

ADDITIONAL CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Step Parent ❑ Legal Guardian ❑ Other _____

ADDITIONAL CONTACT

First Name:	Last Name:	Cell Phone: ( )	Home Phone: ( )
Employer:	Work Phone: ( )	Email:	

Relation to student: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Step Parent ❑ Legal Guardian ❑ Other _____

EMERGENCY MEDICAL AUTHORIZATION

PART 1 - TO GRANT CONSENT — **Only PART 1 or PART 2 below must be completed and signed.**

I hereby give permission for a physician, licensed nurse, or other school employee designated by school administration, to administer medical treatment to my child in an emergency, including as a result of athletic participation, that threatens the life or health of my child. I understand that school staff and medical personnel will be acting in good faith, in accordance with applicable law and in the best interest of my child. DPSCD staff will adhere to applicable policies as well. By providing this consent, to the extent permitted by law, I voluntarily with full knowledge of its significance, release and hold harmless DPSCD, the Board of Education and its staff, contractors, agents, and volunteers from liability resulting directly or indirectly from the medical treatment provided. I further authorize a physician, licensed nurse or other school employee designated by school administration to cause my child to be transported to the nearest hospital for treatment in an emergency. I hereby assume responsibility for the costs of any medical treatment and transportation provided to my child which may include indemnification of DPSCD for such costs.

Parent or Guardian Signature _____ Print Name _____ Date _____ (MM/DD/YYYY)

Note: The above information will be shared with appropriate staff as necessary. This includes, but is not limited to, administrators, teachers, support staff, bus drivers, food service staff, custodians, coaches, and substitute employees. Please, notify the school nurse of any concerns.

PART 2 - REFUSAL TO CONSENT — **Do not complete PART 2 if you completed PART 1.**

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish school/district authorities to take the following action:

Parent or Guardian Signature _____ Print Name _____ Date _____ (MM/DD/YYYY)

DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT

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Annual Health Information

Dear Parent/Guardian: The information on this form will be used to meet your child's health needs at the school. Please complete all sections of the form and then sign and return it to your child's teacher as soon as possible. Every student must have a new form completed each year.

School Name:	Grade:	Is your child new to the district? ☐ Yes ☐ No

Student's First Name:	Middle Name:	Last Name:	Suffix (Jr., III, etc.)

Date of Birth:
(MM/DD/YYYY)

Parent/Guardian Name:	Relationship to Student:
Home or Cell Phone: ( )	Work Phone: ( )

What type of health insurance does your child have?

- ☐ Medicaid
- ☐ Private
- ☐ Unsure
- ☐ My child does not currently have health insurance

If your child has Medicaid, please mark the plan name:

- ☐ Aetna
- ☐ Blue Cross Complete
- ☐ HAP Midwest
- ☐ McLaren
- ☐ Meridian
- ☐ Molina
- ☐ Total Health Care
- ☐ United
- ☐ Other

What type of dental insurance does your child have?

Healthy Kids *(please select which plan)*
- ☐ Blue Cross Blue Shield
- ☐ Delta Dental
- ☐ Unsure which Healthy Kids plan

- ☐ Private
- ☐ Unsure

Does your child have any of the following health conditions?

HEALTH CONDITION	YES	NO	HEALTH CONDITION	YES	NO	HEALTH CONDITION	YES	NO
Severe allergies (food, insects, drugs, latex)			Allergies *(seasonal)*			Heart Problems		
			Anxiety			Lead Poisoning		
If yes, please state what your child is allergic to (certain foods, insects, latex, etc) _____ _____ _____ _____			Asthma or breathing problems			Pregnant		
			Attention Deficit Hyperactivity Disorder			Seizures		
			Behavioral Problems			Sickle Cell Disease		
			Bladder or Bowel Problems			Speech Problems		
			Dental Problems			Vision Problems		
If yes, please check the reaction that occurs: ☐ Hives ☐ Swelling ☐ Trouble breathing ☐ Other			Depression			Wears Glasses		
			Diabetes			Other Health Conditions, please list:		
			Head Injury or Concussions					
			Hearing Problems					

MEDICATIONS AND/OR SPECIAL PROCEDURES*

Does your child require any daily medications to be taken at school?	❑ Yes* ❑ No
Does your child require any emergency medications be kept at school?	❑ Yes* ❑ No
Does your child require any special procedures to be done at school? *(g-tube feeding, catheterization, etc.)*	❑ Yes* ❑ No

**** If you answered yes to any of the above questions under Medications and Special Procedures, please complete the Authorization for Release of Medical Information form. If needed, please have your provider complete the Prescribed Medication form. Both forms are available at detroitk12.org/enrollnow and must be renewed every year.***

MEDICAL CARE PROVIDERS

Doctor's Name:	Phone: ( )	Address:
Date of last physical: (MM/DD/YYYY)	❑ Unsure	
Dentist's Name:	Phone: ( )	Address:
Date of last dental exam: (MM/DD/YYYY)	❑ Unsure	

Medical Specialist (optional):	Local Hospital:
Phone: ( )	Emergency Room Phone: ( )
Address:	Address:

FAMILY NEEDS

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? ❑ Yes ❑ No

ACKNOWLEDGMENTS & SIGNATURE

I certify that this information is correct to the best of my knowledge and understand that it is my responsibility to inform the school if any of this information changes. I also understand that this information may be shared with need-to-know staff at my child's school in order to keep my child safe and protected while at school.

Parent or Guardian Signature	Print Name	Date (MM/DD/YYYY)

TO BE COMPLETED BY OFFICE STAFF

	DATE	STAFF PERSON
Form received		
Information entered into Student Information System		

DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT

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Consent to Release Health Information

STUDENT INFORMATION

First Name:	Middle Name:	Last Name:	Date of Birth: (MM/DD/YYYY)
Parent/Guardian First Name:	Parent/Guardian Last Name:	Home or Cell Phone: ( )	

CONSENT FOR RELEASE OF INFORMATION

By signing this Consent to Release Information form, I consent to the following:

- I authorize my child's school to disclose the following student information to the individuals/groups listed below: child's family and emergency contact information, attendance and disciplinary records, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education records, section 504 accommodation plan and any information related to medical conditions, such as asthma, diabetes or seizures.
  - My child's Health Care Provider(s)
  - My child's Health Insurance Plan
  - Michigan Dept. of Health and Human Services and Detroit Health Dept. (Immunization records only)
  - School-based health service providers – see below
- I understand that sharing this information will allow DPSCD to work with each of these individuals/groups to coordinate care, provide outreach services if necessary, and keep my child healthy and safe at school.
- I understand that I am entitled to receive a copy of any disclosed records. *(If you wish to receive a copy please provide an email or street address to which where the records should be sent.)*
- I understand that these individuals may further use records provided by DPSCD for contacting me and/or verifying information for student health related purposes.
- I understand that my authorization to allow sharing the above information is voluntary and that it expires when my child leaves the school district, or graduates. **I understand that I may revoke this authorization at any time by submitting a note or letter in writing to the school administration office.**

School-based health service providers may include any of the following:

- School Based Health Centers (SBHC): ability to diagnose and treat many common conditions such as sore throats, headaches, and ear infections, and also manage chronic health conditions. The SBHC may also provide behavioral health services.
- Dental Services: may include oral health education, screenings, fluoride varnish application, preventative care and cleaning, restorative/corrective care.
- Vision Services: may include screening, examination, treatment and/or corrections such as eyeglasses.
- Immunization Services
- Behavioral Health Services

In order for your child to receive these services, from these providers, you will need to complete a separate enrollment form with each of the providers.

Parent/Guardian Name:	Relationship to Child:	Date: (MM/DD/YYYY)

DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT
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Permission for Collaboration for Your Child's Health

Health Care providers, Health Plans and Health Departments

FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)

What is FERPA?
The Family Educational Rights and Privacy Act (FERPA) is a Federal law that protects the privacy of student education records. Generally, schools must have written permission from the parent, or student if over 18, in order to release any information from a student's education record.

Permission for what?
Detroit Public Schools Community District is requesting your consent because we may need to share information contained in our student records with your child's Health Care Provider, Health Insurance Plan, a School-Based Health Service Provider, or as required by law, including to the Michigan and Detroit Departments of Health. Health Care Providers are the physician(s) or nurse practitioner(s) who take care of your child, as noted in the district's records. A Health Plan is an organization that administers your child's health care benefits, such as Medicaid or a health insurance company.

Why is this important?
This consent form allows the district, when requested or necessary by law, and/or to assist with coordination of health care, including benefits, by sharing health information from the student's education record. Without your consent, the district is limited in how it can collaborate with your child's Health Care Provider, Health Insurance Plan, or a School-Based Health Service Provider to help you or your child.

What this form does not do.

- This form only authorizes the district to disclose information for limited purposes, with your consent. Each Health Care Provider, Health Insurance Plan, or a School-Based Health Service Provider may have its own way of getting permission from you for them to share information with the district.
- Your signature does not authorize the district to obtain medical treatment for your child on your behalf.

Please help us link you and your child to health services by signing and returning the previous page.

VACCINES FOR CHILDREN

Immunizations play an important role in keeping students healthy by preventing the onset and spread of disease.

The Michigan Public Health Code requires all children who attend school in Michigan to have an up-to-date immunization history or a valid waiver on file.

Childhood Recommended Immunizations (*School Required)

- Diphtheria, Tetanus, Pertussis (DTP, Dtap, Tdap)*
- Polio*
- Measles, Mumps, Rubella (MMR)*
- Hepatits B*
- Meningococcal Conjugate (MenACWY)*
- Meningitis B* (16 & Older)
- Varicella (Chickenpox)*
- Influenza
- Hepatitis A
- Human Papillomavirus Vaccine (HPV)
- Pneumococcal
- H. *influenzae* type B (Hib)*

COVID-19 Vaccines are available for students, for more information visit https://bit.ly/375Cyhs

For more information on Immunizations, visit https://bit.ly/3DWhE0f

Michigan law requires that each student possess a certificate of immunization at the time of registration or no later than the first day of school. Please provide this certificate to your school administrative team.

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Directory Information Opt-Out

The Family Educational Rights and Privacy Act, a federal law, and Detroit Public School Community District ("District") Board Policy allows districts to disclose designated "directory information" to third parties, unless a student's parent or legal guardian opts out.

Directory information includes the student's name, school name, participation in officially recognized activities and sports, height and weight (if member of an athletic team), date of graduation, awards received, telephone numbers and/or home addresses (for inclusion in school or PTA directors), and school photos or videos of students participating in activities, events or programs. Only directory information regarding a student shall be released to any person or party, other than the student or his/her parent, without written consent.

Director information is commonly used in school publications, yearbooks, activity and athletic programs, television productions, web sites, as well as inquiries from community partners, other schools, and potential employers. In addition, the District is required by law to provide, upon request, military recruiters with the same access to directory information as is provided to prospective employers.

We take student data privacy seriously. Parents or guardians should complete this Directory Information Opt-Out Form if they do not want some or all the directory information shared with third parties. **The form can be completed online at https://bit.ly/DPSCDoptout.**

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DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT

Vaccine Consent Form

Student Name: _____ Birth Date: _____ Age: _____

Street Address: _____ City, State, Zip: _____

Telephone: _____ Male ☐ Female ☐

School Name: _____ Grade: _____

VFC Eligibility:

Insurance Type (circle): ☐ **Private** ☐ **Medicaid** ☐ **No Insurance** ☐ **Under-insured** ☐ **American Indian/Alaskan Native**

Parent/Guardian Name: _____

CONSENT FOR VACCINATION: Detroit Public Schools Community District (DPSCD) will review my child's information in the Michigan Care Improvement Registry (MCIR). Based on the information in MCIR, I authorize the DPSCD and/or its School-Based Health Center Partners to administer all recommended or needed vaccines for his/her age. This consent form authorizes the administration of multiple doses of a vaccine, as medically indicated. Combination vaccines will be used as available, unless contraindicated.

I have read and understood the Vaccine Information Statement(s) available online at MDHHS - Vaccine Information Statements (VIS) (michigan.gov) for the recommended vaccine(s). I understand the benefits and risks of the recommended vaccine(s) and I understand the immunization(s) administered is entered into MCIR. This consent form will expire after the last vaccination is given in a vaccine series.

Parent/Guardian Signature: _____ **Date:** _____

Please check Yes or No	**Yes**	**No**
Does the child have any allergies to medication, food, a vaccine component, or latex?		
Has the child had a serious reaction to a vaccine in the past?		
Has the child had a health problem with lung, heart, kidney, or metabolic disease (diabetes), asthma, or a blood disorder? Is he/she on long term aspirin therapy?		
Has the client, a sibling, or a parent had a seizure? Has the client had brain or other nervous system problems?		
Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
In the past 3 months, has the client taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?		
In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
Is the client pregnant or is there a chance she could become pregnant during the next month?		
Has the client received vaccinations in the past 4 weeks?		
Has the client received a TB skin test this month?		

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DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT

PLEASE NOTE!!!!! VACCINE REFUSAL SECTION BELOW			
COMPLETE SECTION BELOW IF YOU DO NOT WANT YOUR CHILD TO RECEIVE A VACCINE			
VACCINE REFUSAL: Place a check next to the vaccine(s) that you **do not** want your child to receive and **sign.**			
☐ DTaP/Tdap/Td	☐ Pneumococcal	☐ Meningococcal ACWY	☐ Polio
☐ Hib	☐ MMR	☐ Influenza	☐ HPV
☐ Hepatitis A	☐ Hepatitis B	☐ Men B	☐ Varicella

My child, as named above, should not receive the above vaccines as indicated by a check mark. I understand the possible consequence(s) of not allowing my child to receive the recommended vaccines.

Parent/Guardian Signature: _____ **Date:** _____

For Staff Use Only:

Verbal Consent for Vaccination

Name of DPSCD Staff Member Making the Call:

_____

Name of Parent or Guardian: _____

Date: _____

Time: _____

Parent/Guardian has provided authorization for DPSCD and/or its School-Base Health Center Partners to Provide Vaccines to the student. Please circle the appropriate answer. (Yes) (No)

Additional Comments: _____

_____

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STUDENT MEDIA RELEASE

PLEASE PRINT ALL INFORMATION

To the parent or guardian of: _____
(Print Student's Name)

On occasion, Detroit Public Schools Community District-approved non-commercial video, photographic and/or audio production crews may be present at the school or at a Detroit Public Schools Community District-sanctioned activity your child attends, in order to highlight the activity, school, student, original student work or the District in the interest of promoting public education. If you consent to your child's participation or showcase of their original work in the video/photographic/ audio, productions/interviews/activities or social media postings that may take place, please sign below after reading the following.

I, _____, am the parent/guardian of the above-named student.
(Print Parent/Guardian Name)

In the interest of public education, I hereby authorize the Detroit Public Schools Community District, its Board of Education, and the non-commercial production crews, acting through their authorized employees or agents, to use, publish, and copyright audio and/or visual reproductions of the above-named student's voice and/or image, and/or original student work alone or with other persons, with or without the use of the student's name for the sole use in the interest of public education connected with a DPSCD authorized project.

This release is in effect in perpetuity from the date _____
(Print Student's Name)
becomes a student of _____ until the date his/her
(Print School Name)
status at DPSCD or at the school as a student terminates. I hereby release and hold the Detroit Public Schools Community District harmless from any liability, any and all injuries, claims, damages or costs arising from the use of images or recordings of any type and waive any request for remuneration.

_____ _____
Parent/Guardian Signature Date

_____
Address, City, Zip

KEEP THE COMPLETED FORM AT YOUR SCHOOL.

Office of Communications & Office of Marketing
ph: 313-873-3494 | communications@detroitk12.org