APRIL

NMS NEWSLETTER

NORDONIA MIDDLE SCHOOL WWW.NORDONIASCHOOLS.ORG

The **Sagamore Voice** shined a well deserved spotlight on **Mr. Gura's** classroom! The article highlighted the coffee and tea cart service that **Mr. Gura's** students provide to the **NMS** staff every Tuesday and Thursday. The staff is so appreciative of the service and the ability to interact with the students on a regular basis.
Click here to view the full article.

Ohio Middle Level Association Breakfast of Champions honored two **Nordonia Middle School** students in March.

Addison Vojtush and Quinn Kinkoph were honored for having outstanding character, their volunteer efforts, their excellent grades and work ethics.

Congratulations ladies!

Congratulations to the **Nordonia Middle School Science Olympiad Team** that brought home 24 individual event medals and a 2nd place overall team trophy at regionals. The team qualified for the **Science Olympiad State Competition** on April 27th at **Ohio State University.** Way to go Knights!

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Congratulations to the Power of the Pen Team!
Daisy Hunt (7th) earned 1st place out of 88 writers.
Daisy Hunt, Ava Oravec (8th), Brooklyn Ring (8th), and Madeline Newyear (8th) will compete at the state tournament at **Ashland University on May 17th.** Also, **Ava Oravec's** story**, "I Don't Remember"** will be published in the **"Book of Winners, The Winners of 2024"** book.

Thank You PTSA

Thank you to the **NMS PTSA** for putting together two fun events for our students!

Fun N Stuff on March 28 and the **Sneaker Ball** on April 12. The students had a great time!

Our **PTSA** works hard behind the scenes to make these events happen and we are so grateful!

Jazz Band

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Nordonia's first District Art Show will be the weekend of **April 26th-28th**. **ALL** of our student artists will have their work showcased at **Nordonia High School**. Come up, admire, and be inspired by our talented students! **Friday 4-8, Saturday 10-4, and Sunday 10-2**

Upcoming Events

4/22 - Meet the Volleyball Coaches - 6:00pm - NHS Cafeteria
4/24 - All District Band Concert - 6:30pm - NHS Gym
5/11 - 7th & 8th Grade OMEA Band Contest - Streetsboro HS
5/13 - PTSA Meeting - Board Members Only
5/15 - 7th and 8th Grade Jazz Ensembles Concert - 7:00pm - NMS Gym
5/16 - 8th Grade Rubber Ducks Annual Education Day
5/21 - Spring Choir Concert - 7:30pm - NHS Auditorium
5/24 - Spirit/Pep Assembly
5/27 - Memorial Day - NO SCHOOL
5/29 - Promotion Ceremony - Team Gemini - 12:45pm - NMS Gym
5/30 - Promotion Ceremony - Team Phoenix - 12:45pm - NMS Gym
5/31 - Promotion Ceremony - Team Draco - 12:45pm - NMS Gym
6/4 - Last Day of School

This is our final reminder that on **Tuesday, April 23rd, The Akron Children's Hospital School Based Health Center** will be offering a **Vaccine Clinic** at the **Middle School Building Clinic** for the following 3 vaccines:

#1 - Tdap, #2 - MCV4, and #3 – HPV

Two of these vaccinations are required prior to or during their 7th grade year: both Tdap and MCV4. If your child did not receive either of these required vaccinations, this is an opportunity to acquire one or more vaccines for your student during their school day. **A parent immunization letter and vaccine consent for students are below, to participate please complete the forms and return to the Middle School Office ASAP.**

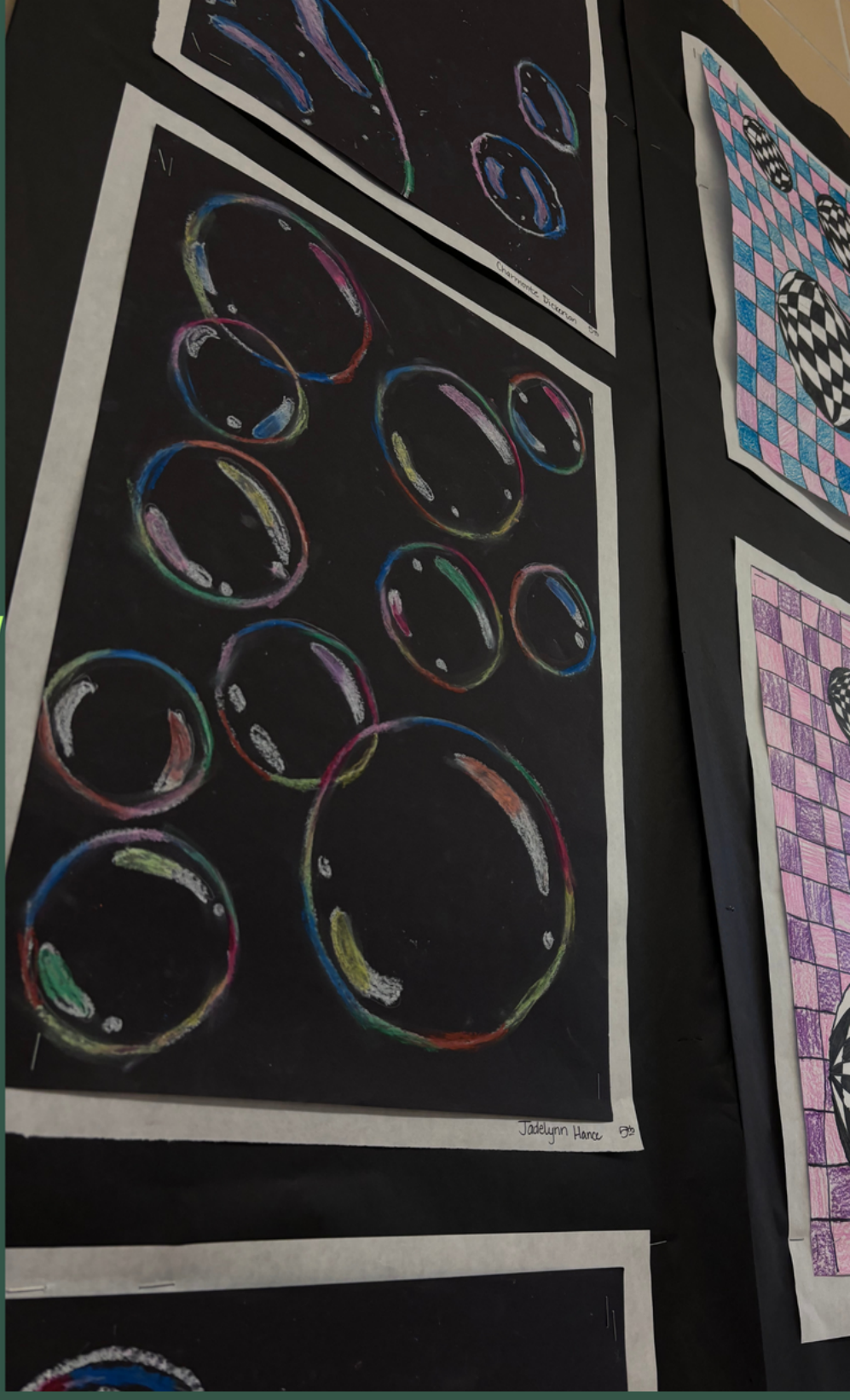
NORDONIA HILLS CITY SCHOOLS DISTRICT ART SHOW

Nordonia High School Small Gym

Friday, April 26th,
4:00 – 8:00 p.m.

Saturday, April 27th,
10:00 a.m. – 4:00 p.m.

Sunday, April 28th,
10:00 a.m. – 2:00 p.m.



Dear Parent/Guardian,

Akron Children's Hospital, School Health Services can provide any needed vaccination your student is due for. Vaccines are provided in your student's school building during school hours. We accept most insurance plans, including no insurance. Please check with your insurance provider to confirm vaccine coverage in school. Participation is voluntary. Only students with parent/guardian completed consent form can receive vaccinations. **Review the vaccine information sheet (VIS) by scanning the QR codes next to the vaccine and return BOTH this letter and the attached consent form by:**

All students,11 years old and older are eligible to receive the following vaccines:

I would like my student to receive the below vaccines. **(check mark)**

	TDAP	Tdap Information	LOT EXP NDC LARM RARM
	Meningitis B (only 16 years old and older)	Meningitis B Information	LOT EXP NDC LARM RARM
	Meningococcal ACWY (MCV4)	MCV4 Information	LOT EXP NDC LARM RARM
	Gardasil (HPV)	HPV Information	LOT EXP NDC LARM RARM

Student's Name **and** Date of Birth:

Parent/Guardian Signature:

Parent/Guardian Name:
(printed)

Parent/Guardian Phone Number:

Date:

Student's School Building: **Nordonia Middle School**

How can my student participate?
Return this form **and** attached completed consent form by **ASAP**.
If you have additional questions, please contact the School Based Health Center at 330-543-7242. We hope to see your student in the clinic!
Thank You!

School Based Health Center,
Akron Children's Hospital,
School Health Services

Akron Children's Hospital
School Based Health Center

Vaccine Consent Form

Only circled vaccines will be offered at this event. See attached vaccine information sheets.
Influenza (Flu) DTaP/Tdap/Td Meningococcal/Men B MMR Varicella Polio
Hepatitis B HPV Hepatitis A Pneumococcal Hib

School Name:_____

PLEASE COMPLETE ALL OF THE INFORMATION BELOW- **Please print using ink** (incomplete forms will not be accepted)

FIRST NAME (of student)		**LAST NAME (of student)**	
Gender: Male Female	**Birthdate: (mo/day/yr)**	**Age**	**Grade**
Home Phone #		**Cell Phone #**	
Address		**City**	**Zip Code** / **State**

The current health care laws require us to bill your insurance company for the vaccine(s). Answers are always confidential. Please fill out the following questions pertaining to your child's Health Insurance.

Parent/Guardian Information

First Name:	Last Name:	Phone #:	Relationship to Student:

REQUIRED INSURANCE INFORMATION (MUST CHECK AN APPROPRIATE BOX)

Insurance Name:	
Insurance Address:	
Subscriber Name/ ID #	**Subscriber DOB:**
MMIS:	**Group #:**

☐ **NONE, please connect me to Children's Financial Counselor**

All services provided are billed to insurance. If you do not have insurance, Children's will connect you to financial assistance.
No child is denied services for inability to pay.

STUDENT HEALTH HISTORY

Allergies: ☐ **YES (list below)** ☐ **NO**

Medications: ☐ **YES (list below)** ☐ **NO**

Other medical problems/health concerns: ☐ **YES (list below)** ☐ **NO**

VACCINATION & HEALTH RELATED QUESTIONS

1. Has your child ever had a life-threatening reaction(s) after a previous dose of any diptheria, tetanus, or pertussis containing vaccine?	YES / NO
2. Has your child ever had a life-threatening allergice reaction after a previous dose of meningococcal ACWY vaccine?	YES / NO
3. Has your child ever had a condition called Guillain Barre Syndrome (GBS) ?	YES / NO
4. Does your child have a blood disorder such as hemophilia?	YES / NO
5. Has your child ever had seizures or another nervous system problem?	YES / NO

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT 330.543.7242

By signing below, I have read and understand the supplemental CDC Vaccine Information Sheets and my signature provides consent for my child to receive the designated vaccines as indicated on this form.. I further agree that I will promptly inform the School-Based Health Center in writing of any changes in my child's physical or dental health and any change in the custody of my child which affects my ability to provide this consent on behalf of my child.

NOTE: In some situations Ohio law permits a minor to consent to medical care without parental consent. For example, parental consent is not required for contraception, pregnancy testing, and prenatal care; sexually transmitted disease testing and diagnosis; HIV testing; treatment of drug and alcohol related conditions; and certain outpatient mental health services. Further, parental consent is not required for the application of first aid treatment or in an emergency.

X_____ X_____ _____
Signature of Parent/Guardian | Printed Name of Parent/Guardian | Date

X_____ X_____ _____
Signature of 2 Witnesses if Verbal Consent *(health care personnel only)* | Printed Name of 2 Witnesses if Verbal Consent *(health care personnel only)* | Date

Akron Children's Hospital

School Based Health Center

SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES CONSENT FORM

SCHOOL-BASED HEALTH CENTER SERVICES

Throughout this document the use of the term "I" will refer to "I and/or my parents or guardians". The use of the term "me" "myself" or "my" shall refer to the student. The use of "Children's" will refer to Akron Children's Hospital, its physicians, nurses, other health care providers, employees, attending physicians and other physicians, and their assistants or designees.

I and/or my parent(s) or guardian(s) consent to let the physicians, nurses, other health care providers, and employees of Akron Children's Hospital, attending physicians and other physicians, or any of their assistants or designees, do all things that may be needed to diagnose, treat and care for the needs of the above-referenced student. Children's is a teaching hospital and I understand and agree that people who are in training, including, but not limited to, fellows, residents, and students, may assist or participate in my care. I understand and agree that Children's may take photos, video, or audio recording of me and use them for clinical, internal education purposes, legal purposes and quality improvement purposes. I understand and agree that Children's may at its discretion provide certain services to me by remote means called "telehealth". Children's may keep, preserve and use, or properly dispose of any tissue, samples, parts or organs that are taken during operation(s) or procedure(s). I understand that the practice of medicine is not an exact science and that no guarantees have been made about the results of my examination or treatment at Children's.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: I agree to pay all bills for my care, including bills that insurance benefits do not pay. This includes bills for Children's, physicians, or other entities that provided services during my care. I authorize Children's to bill my insurance carrier and request that payments be made directly to Children's. I assign to Children's, my physicians, and other healthcare professionals involved in my care, all of my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, Tricare, any other program for which benefits may be available to pay Children's for the services provided to me, or other payments or judgements. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer regarding those services. I understand that a financial agreement will be established. I agree to cooperate and provide complete and accurate information as needed to establish my eligibility for such benefits.

PATIENT RIGHTS/PRIVACY INFORMATION: I understand I have the right to take part in decisions about my healthcare and plan for treatment. I have received, read, or had explained to me, and acknowledge receipt of the following documents and/or information, and all my questions have been answered.

Patient Rights and Responsibilities	Advance Directive Information (Patients 18 years and older)
Complaint/Grievance Procedure	Free Hospital Care Information
Health Information Exchange Brochure	"An Important Message from Medicare" (Medicare patients)
HIPAA Notice of Privacy Practices	"An Important Message from Tricare" (Tricare patients)

AUTHORIZATION TO COMMUNICATE: I understand that Children's uses various communication methods including voice calls, computerized calls, computerized text message, email, fax, auto-dialed calls, and pre-recorded messaging for the purposes of sharing clinical/medical results, scheduling appointments, sending appointment reminders, obtaining patient feedback , and communicating/discussing financial responsibilities. By signing this form, I am granting permission to Children's to use all phone numbers and email addresses that I have supplied to contact me regarding this current visit and any future visits. I will be given the opportunity to opt out of future text, email, or phone communications at any time. I understand that my opting out of future text, email or phone communications will not affect, directly or indirectly, my right to receive health care services from Children's.

ALL PATIENTS COVERED BY MEDICAID: I was asked whether any insurance other than Medicaid may cover services provided by Children's. If there is other insurance coverage, I gave that information to Children's.

Privacy Practices

Children's Notice of Privacy Practices is available upon request at any School District building where services are provided. You can also view the Notice of Privacy Practices online at https://www.akronchildrens.org/pages/Privacy-Policy.html. Children's Notice of Privacy Practices describes how Children's may use and disclose you/your child's health information and how you can access you/your child's health information.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

By signing the Authorization For Release of Health Information, you authorize Children's to share you/your child's health information related to the services the School Based Health Center provides to you/your child with the School District, including the School District's nurses, counselors, teachers, and social workers involved in you/your child's care for treatment purposes. Except as provided above and in Children's Notice of Privacy Practices, Children's will not disclose your/your child's health information without your written authorization.

I understand that I do not have to allow release of my child's health information in order for my child to receive treatment, and that I can change my mind at any time and revoke my authorization by writing to the School Based Health Center. However, after a disclosure has been made, I understand that my revocation does not cover information released prior to the revocation. I also understand that health information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal or State privacy law.

Time Period During Which Release of Information is Authorized:

From: Date that form is signed on opposite page
To: Date that student is no longer enrolled in the School

Cookies for a Cause!

Crumbl is teaming up with Special Olympics to donate 15% of their sales each Thursday for the month of April, starting tomorrow! You can treat your friends, co-workers, loved ones, and most importantly, yourself while supporting the Special Olympics.

Crumbl Cookies
509 E Aurora Road in Macedonia

Mention *"Nordonia Hills Special Olympics"* with your purchase.