**Faulconer-Chapman School**
332 SW Cornwall Street
Sheridan, OR 97378
Phone: 971-261-6960 Fax: 503-843-3738

**Start Date:** _____
Office use only

# Request for Student Records

| Student(s) Name | Date of Birth | Grade Level (Current) |
|---|---|---|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |

**To:** _____
**(Name of Former School)**

_____
**(Address)**

_____
**(City, State, Zip)**

**PARENTAL RIGHTS**

I understand that my child's records will be sent to Sheridan School District #48J within the next (10) days. I understand that I also have the right to review the education records of my child at any time after they have been transferred to Sheridan School District #48J (ORS 326.565) and that I may request an amendment of specified contents pursuant to OAR 581-021-0300 if I believe that the contents are inaccurate, misleading, or in violation of the privacy or other rights of the student.

**Please fax the following to (503) 843-3738 (Attn: Records) before mailing:**
- √ 504

**Please mail all Education Records to *Faulconer-Chapman School*, including:**
- √ Cumulative File - Report Cards, Testing, 504, ELL, TAG & Behavior
- √ Health Folder including Immunization Records, Sports Physical & etc.

Mail All Education Records To:

**Faulconer-Chapman School**
**Attn: Records**
**332 SW Cornwall Street**
**Sheridan, OR 97378**

**Please fax the following to Special Programs (503) 843-1515 before mailing:**
- √ IEP eligibility documents

**Please mail all Special Education Records to *Special Programs*, including:**
- √ ORIGINAL Special Education Records (including eligibility)
- √ IEP eligibility documents

Mail All Special Programs Records To:

**Special Programs - Records**
**332 SW Cornwall Street**
**Sheridan, OR 97378**

_____ _____
Parent/Guardian Signature & Relationship (For permission to transfer records) Date

_____ _____ _____
FCS Registrar/Student Services Signature Date Faxed/Mailed Date Received

# Welcome to
# Faulconer-Chapman K-8 School

## To register a new student we ask that you provide the following information:

Student Name: _____ Grade: _____

Parent/Guardian: _____

***My child can start on: _____**

***(Please allow 24 hours for the enrollment process – you will be called with the start date.)***

1. My child is currently on an IEP. ___ yes ___ no
2. My child has a current 504. ___ yes ___ no

   If yes, explain: _____
3. My child is a TAG student. ___ yes ___ no
4. My child is currently an ELL student. ___ yes ___ no
5. My child is currently getting counseling. ___ yes ___ no

   If yes, explain: _____
6. My child has been suspended or expelled from school. ___ yes ___ no

   If current year, explain: _____
7. My child has been in an alternative educational setting. ___ yes ___ no

   If yes, explain: _____

## In addition, we ask that the enclosed forms be completed:

1. Enrollment Information Packet
2. Health Information (Copy of Immunizations)
3. Birth Certificate (Kindergarten)
4. Bus Rider Form (Optional)

## Final steps include:

○ My child would like to be in Band? ___ yes ___ no (Has taken Band for _____ years)

*(Band is offered to students in 5th-8th Grade)*

# SHERIDAN SCHOOL DISTRICT #48J
# Faulconer-Chapman K-8 School
# Student Registration Form

OFFICE USE ONLY

Start Date _____

Teacher/Advisor _____

Student ID # _____

Entry Code _____

**Legal Name as it appears on birth certificates:

| **Legal First Name** | **Legal Middle Name** | **Legal Last Name** | **Nickname and/or Preferred Last Name** |
|---|---|---|---|
| | | | |

| **Home Address – Street** | **City** | **State** | **Zip** | **Mailing Address (If different from home)** |
|---|---|---|---|---|
| | | | | |

| **Primary Phone** | **Sheridan District Resident** ☐ **Yes** ☐ **No** **County:**_____ | **Student's Birthplace** **City** **State** **County** |
|---|---|---|
| | | |

| **Gender** | **Birthdate** (mm/dd/yy) | **Ethnicity:** Is this student Hispanic/Latino? (This information is required by the Federal and State Governments for statistical reports.) | **Grade** |
|---|---|---|---|
| ☐ Male<br>☐ Female | | ☐ Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin, regardless of race.<br>☐ No, not Hispanic/Latino | |

Race: What is student's race? (Select all that apply) (State/Federal Governments require this information for statistical reports.)

- **American Indian or Alaska Native**
  - ☐ **US** (US Indigenous people of Continental U.S. or Alaska. Tribal Affiliation, if known: _____)
  - ☐ **Latin America or Canada** (A person having origins in any of the indigenous people of Canada, Mexico, Central America, S. America or Caribbean.)

☐ **Asian** (A person with origins in the Far East, Southeast Asia, Indian Subcontinent.)
☐ **African American or Black** (A person having origins in any of the black racial groups of Africa.)
☐ **Native Hawaiian or Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam Samoa or other Pacific Islands.)
☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East or North Africa.)

| **School Previously Attended** (Preschool or Previous Sheridan School or Out-of-District School) Grade | School Name | City | State | **Date Last Attended** Month/Year |
|---|---|---|---|---|
| | | | | |

## Priority Contact Information (Parent/Joint Parent/Guardian)

**Child Lives with:** (Circle One) **Parents** ☐ **Mother** ☐ **Father** ☐ **Legal Guardian(s)** ☐ **Foster Parent(s)** ☐ **Other**_____

Is there joint custody of this student? ☐ Yes ☐ No

1. **Relationship to Child:** (Check One) ☐Father/ ☐Mother /☐Stepfather /☐Stepmother /☐Guardian /☐Foster /Other

Name _____

Employer_____ Work Phone # _____ Cell Phone # _____ Other # _____

Email Address _____

2. **Relationship to child:** (Check One) ☐ Father/ ☐Mother /☐Stepfather /☐Stepmother /☐Guardian /☐Foster /Other

Name _____

Employer_____ Work Phone # _____ Cell Phone # _____ Other # _____

Email Address _____

## Non-Custodial Parent/Guardian Information

Is there a Non-Custodial Parent/Guardian? ☐ Yes ☐ No Check to also receive school communication ☐

1. **Non-Custodial Parent/Guardian** _____ **Relationship:** _____

Address _____

Employer_____ Work Phone # _____ Cell Phone # _____ Other # _____

2. **Non-Custodial Parent/Guardian** _____ **Relationship:** _____

Address _____

Employer_____ Work Phone # _____ Cell Phone # _____ Other # _____

# Emergency Information

Please list **two** people, other than parents, we can call to assume temporary care of your child in the event you cannot be reached.

1. Name _____ Relationship _____

   Address _____ Cell Phone # _____ Other # _____

2. Name _____ Relationship _____

   Address _____ Cell Phone # _____ Other # _____

## Sibling(s) Attending Sheridan Schools

Name _____ Grade _____ Name _____ Grade _____

Name _____ Grade _____ Name _____ Grade _____

## Student Medical Information

**Doctor's Name** _____ **Doctor's Telephone** _____

My Child ☐does/☐ does not have health insurance. Name of Plan _____ Policy# _____

| **1. Check health conditions that may affect your child at school.** | 2. List all medications, including inhalers used by your child.* |
|---|---|
| ☐ **Asthma** ☐ **Diabetes** ☐ **Seizure disorder** ☐ **Allergy** ☐ **Other** _____ | 3. Medical Alert ☐ Yes ☐ No _____ |

***If it is necessary for your child to have medication at school, please see the school secretary for the appropriate forms.***

| **Federal Funding:** Under Public Law No. 874, the District can receive federal money for each child if their parent: | | | |
|---|---|---|---|
| ☐ **Works on Federal Land Company:**_____ | ☐ **Lives on Federal Land** | ☐ **Is in the Active Armed Forces Branch:**_____ | ☐ **Both Lives & Works on Federal Land - Company:**_____ |

****Is guardian a member of the Armed Forces on active duty or full time National Guard? ☐Yes /☐No**
(This information is required by the state.)

Migrant Student Information
Did Parent/Guardian move within the last 36 months to work or seek work in agriculture, fishing, or related food processing activity?
☐Yes ☐No
If yes, when? _____

I authorize Sheridan School District #48J to contact directly the persons named on this form, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for health of said child. I will not hold the school district or its employees financially responsible for the emergency care and/or transportation for my child.

_____ _____

**Signature of Parent/Guardian** **Date**

| ***School Use Only*** | | |
|---|---|---|
| Records Requested ☐ | Parents Notified ☐ | Teacher Notified ☐ |
| Birth Verification ☐ | Immunizations Received ☐ | Address Verification ☐ |

*Office Use Only* ☐ **Information Entered Into Database**

**Sheridan School District 48J**
**Student Health Record**

Student _____ Sex: ☐ M ☐ F Birth Date _____
Last First Middle Month Day Year

Parent/Guardian _____
Last First Middle Initial

Address _____ Home Phone _____ Work Phone _____

Dear Parent: Please describe your child's health problems on the form below. It is important that you keep the school informed of any changes in health or medication which would affect your child's performance. If any health conditions are noted below, you must complete the Authorization to Use and/or Disclose Educational and Protected Health Information on the back of this form.

| ****CURRENT HEALTH CONDITIONS**** | ☐ ***NEW HEALTH ALERT ADDED***<br>☐ ***NO HEALTH PROBLEMS TO MY KNOWLEDGE*** (***Please sign and date below) |
|---|---|
| ☐ **CHECK HERE IF ANY OF THE HEALTH CONDITIONS BELOW ARE LIFE THREATENING AND WOULD REQUIRE EMERGENCY MEDICATION OR TREATMENT AT SCHOOL. Please circle the condition(s) below that are life threatening.** | |
| ASTHMA | Triggers/Causes: |
| | List medications needed at school: |
| BLOOD DISEASE<br>Anemia, Hemophilia, etc. | Type: |
| | Special needs: |
| CARDIAC | Type: |
| | Limitations: |
| DIABETES | ☐ Type I ☐ Type 2 Medications: |
| | Special needs: |
| Food Intolerance (Dairy, etc.) | Type: |
| | Type: |
| EATING/SWALLOWING DIFFICULTIES | Describe: |
| | Special needs/Equipment: |
| FOOD ALLERGY:<br>□ Life Threatening - (requires Epi-pen)<br>□ Mild | Food(s): |
| | List emergency medication(s) needed at school: |
| HEARING IMPAIRMENT OR COMPLETE LOSS | Describe: |
| | Special needs: |
| INSECT STING ALLERGY:<br>□ Life Threatening - (requires Epi-pen)<br>□ Mild | Insect Type: |
| | History of life threatening reaction? ☐ Yes ☐ No Emergency medications needed at school: |
| | History of localized swelling only? ☐ Yes ☐ No Medications needed at school: |
| LATEX ALLERGY | Special needs: |
| | List emergency medication(s) needed at school: |
| MALIGNANCY/CANCER | Type: |
| | Special needs: |
| NEUROLOGICAL PROBLEM<br>Hydrocephalus, Cerebral Palsy, etc. | Type: |
| | Special needs: |
| ORTHOPEDIC PROBLEM<br>Arthritis, Muscular Dystrophy, etc. | Type: |
| | Special needs: |
| RESPIRATORY PROBLEM<br>Cystic Fibrosis, etc. | Limitations: |
| | Medication: |
| | Special needs: |
| SEIZURE DISORDER<br>Epilepsy, etc. | Type: |
| | Medication: |
| URINARY/KIDNEY DISORDER<br>Nephritis, etc. | Type: |
| | Special needs: |
| VISION IMPAIRMENT OR COMPLETE LOSS | Describe: |
| | Special needs: ☐ Glasses ☐ Contacts |
| OTHER HEALTH PROBLEMS | Describe: |
| | Special needs: |
| TAKING MEDICATION REGULARLY for a health condition not listed above. | List: |
| | |

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

**Doctor or Clinic Name:** _____

**Doctor or Clinic Phone Number:** _____

**Sheridan School District 48J**
**AUTHORIZATION TO USE AND/OR DISCLOSE EDUCATIONAL AND PROTECTED HEALTH INFORMATION**

**1. I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding my child.**

_____ _____
Student/Child's Name Date of Birth

_____ **Sheridan School District 48J**
Other Names Used by Student/Child School or Program Name

Name and address of health care provider/doctor authorized to:
☐ Send/disclose protected health information
☐ Receive/use educational information

_____
_____

Name and address of school authorized to:
☐ Send/disclose educational information
☐ Receive/use protected health information

Sheridan School District 48J
435 S. Bridge St., Sheridan, OR 97378

**2. I understand that this information will be used for the following purposes (check all that apply):**

| | |
|---|---|
| ☐ Determining eligibility for Special Education or other services | ☐ Developing an appropriate Individualized Education Program |
| ☐ Determining student/child's current levels of performance | ☐ Other (specify): _____ |
| ☐ Developing an individualized health plan | |

**3. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:**

| | | |
|---|---|---|
| ☐ Physician's Eligibility Statement | ☐ Educational Information | ☐ Psychological Evaluations |
| ☐ Health Assessment Statement | ☐ IEP document | ☐ Social work reports |
| ☐ History and physical exam | ☐ Clinic records | ☐ Other: _____ |
| ☐ Entire medical record | ☐ Communicable disease(s) | _____ |
| ☐ Prenatal information | ☐ Progress notes | |

**4. By initialing the spaces below, I authorize the use/disclosure of the following information. Specific records requested must be listed below, e.g., assessment, treatment plan, discharge plan.**

_____ Drug/alcohol diagnosis, treatment or referral information requested: _____
_____ HIV/AIDS related records requested: _____
_____ Mental health related information requested: _____
_____ Genetic testing information requested: _____

**5. I understand that:**

a. This authorization is voluntary and I may refuse to sign it without affecting my child's health care.
b. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR 164.524)
c. I may revoke this authorization at any time by notifying Sheridan School District 48J in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.
d. Federal policy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.
e. Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

**6. I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.**

_____
Signature of Parent/Legal Guardian/Student/Child Date Relationship

This authorization expires _____ (month/day/year) (not to exceed one year from date of signature above)

Student Name _____

# Sheridan School District 48J
# Responsible Technology Use Agreement

Students and Parents/Guardians: Please read this together, sign and return to the main office.

**State of Purpose**

Sheridan School District Staff and students use technology and internet-based tools (e.g. Google Apps for Education, Online Curriculum, online multimedia, etc.) in their classrooms on a regular basis to meet the district's standards and prepare students to live and work in the digital age. These technologies improve student communication and collaboration skills, provide a real audience, and extend learning beyond the classroom walls while building digital citizenship skills. Student access to technology will require responsible, courteous, efficient and legal use. Our goal in providing access to these resources is to enhance the education of our students and to educate them in responsible and appropriate use. It is important that students and parents recognize that information posted on the internet is public and permanent and needs to be appropriate.

**Terms of Agreement**

1. I agree to follow teacher/building/district instructions when using technology and will use technology carefully, productively, appropriately, and primarily for school-related purposes.
2. I agree to be polite, considerate, and to use appropriate language, I agree to never use technology to bully, abuse, harm or frighten others.
3. I agree to not search or view obscene or offensive materials, access inappropriate websites or engage in hacking or vandalism.
4. I agree to tell an adult if I read, see, or access something inappropriate, or I witness inappropriate use of technology. I agree to not interfere with any filter or security measure.
5. I agree to use technology responsibly and to conserve school, district resources, such as server space, bandwidth, and printing capacity.
6. I agree to not share passwords, except with my teacher or parent/guardian. (FERPA). I agree that I will use complex passwords.
7. I agree to only use my own files and folders I will not access another individual's files and folders without their permission.
8. I agree that I will not reveal or post personal information belonging to myself or another person (i.e. passwords, address, telephone number, photos).
9. I agree to adhere to copyright laws and license and terms of use agreements.

**Violations of Responsible Technology Use Agreement**

- Suspension of computer privileges
- Notification of parent/guardian
- Detention, suspension, expulsions from school and school-related activities
- Legal action and/or prosecution

I understand that my use of any district technology (computer, network, internet, resources, etc.) will be monitored. I understand that if I violate this agreement, the district's policies and procedures, or student handbook, I may not be able to use technology or may experience other appropriate consequences. I acknowledge that my communications while using district technology (i.e. Google Apps) is neither private nor confidential.

Students and parent/guardian: By signing my name below I agree to these terms and I have read and discussed this Responsible Technology Use Agreement.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

# Faulconer-Chapman School

## Release of Information

(Only complete this form if you DO NOT APPROVE)

**The Family Educational Rights and Privacy Act (FERPA)** requires that Sheridan School District, with certain exceptions, obtain written consent prior to the disclosure of personally identifiable information from a child's educational records. Sheridan School District may, however, disclose appropriately designated information without written consent, *unless you advise the District to the contrary* in accordance with District procedures.

**Sheridan School District believes this information is generally not considered harmful or an invasion of privacy if released.**

Some examples of when information might be released include publishing student accomplishments in the local newspaper or a press release, posting photos of students on the school website, printing the student's information in a school directory or publishing the student's name and photo in the yearbook.

**Information is only released under administrative direction as appropriate; information considered by the District to be detrimental will not be released.**

Parents and guardians have the right to prevent the District from releasing information regarding their child. To exercise this right, requests must be submitted in writing to the school within fifteen days of annual public notice.

**If you *APPROVE* the release of your child's information,**
**you *DO NOT need to complete* and return this form.**

**If you do NOT APPROVE the release of your child's information,**
**please complete the form on the next page**
**and return to your child's school.**

Sheridan School District collects release of information status once at each educational level. Parents and guardians will automatically be prompted to update their selections upon registering a new student, registering a new Kindergartener and during registration when your child is entering the 6th grade. Parents may change their release of information selections at any time; however, you will need to submit the change in writing to the school.

****For additional information on Family Educational Rights and Privacy Act you may visit the U.S. Department of Education -** http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html

# Faulconer-Chapman School

## Release of Information

****Only complete this form if you <u>DO NOT APPROVE</u> of the release of your child's information****

Student's Name _____ Grade _____ Date _____

**Elementary / Middle School**

❑ Do NOT release ANY of my child's directory information

❑ My child's directory information MAY be released, EXCEPT for the following:

- ❑ Exclude photo from release
- ❑ Exclude address, name/ID, and phone number from release

**Do not Release any information to:**

- ❑ Military
- ❑ Higher Education
- ❑ Companies
- ❑ Organizations
- ❑ Individuals

**If you have chosen to not approve and have filled the form out, please return to your child's school.**

# State of Oregon - Language Use Survey

**<u>This document is given when a student enters a school district for the first time.</u>**

The State of Oregon honors the languages and cultures of its people and respects all languages in our schools. We encourage the revitalization and preservation of indigenous languages and multilingualism.

This document will allow the school to determine if your student qualifies for screening to receive additional instruction to learn the English language.

**Student Name: _____ Grade: _____ Date: _____**

**Parent/guardian name: _____**

**Parent/guardian signature: _____**

| Information | Questions |
|---|---|
| This section will allow the school to know if your student qualifies for screening to receive additional instruction to learn the English language. | 1. What language(s) are primarily used in the home?<br><br>_____<br><br>2. What was the first language(s) that your student learned?<br><br>_____<br><br>3. What language(s) does your student use most frequently at home?<br><br>_____ |
| This question will let the school know if you, the parent/guardian, need an interpreter or documents translated. This has no cost.<br><br>*This section is for informational purposes only and is not used to identify if your student needs supports to learn the English language.* | In what language(s) would you prefer to receive communication from the school?<br><br>_____ |

# VISION AND DENTAL SCREENING CERTIFICATION FORM

Student Name: _____ Date of Birth: _____Grade:_____
(Please print: Last Name, First Name)

**Oregon Law now requires a child who is 7 years of age or younger to have dental and vision screenings before entering school for the first time.** For information about vision requirements see *2013 Oregon HB3000 Section 1: (2)(a) through (3)(b).* For information about dental requirements see *2015 Oregon HB2972 Section 1: (2)(a) through (3)(c)*
**Parents/Guardians please complete and sign both** Vision and Dental Screening Certifications.

## VISION SCREENING CERTIFICATION **(Please check the appropriate box)**

☐ My Child has received a vision screening.

Most recent screening or eye exam date: _____

Was a follow-up recommended? (circle) Yes☐ No☐ If so what date: _____

Name of Provider: _____

☐ I have previously submitted certification to the school office at _____

☐ I am not providing certification of vision screening/exam due to my religious beliefs.

_____ _____

Parent/Guardian Signature Date

## DENTAL SCREENING CERTIFICATION **(Please check the appropriate box)**

☐ My Child has received a dental screening within the last 12 months.

Most recent screening or dental exam date: _____

Was a follow-up recommended? (circle) Yes or No If so what date: _____

Name of Provider: _____

☐ I have previously submitted certification to the school office at _____

☐ I am not providing certification of vision screening/exam due to my religious beliefs.

☐ The dental screening is a burden because:

(A) The cost of obtaining the dental screening is too high;
(B) The student does not have access to a screener or;
(C) The student was unable to obtain an appointment with a screener

_____ _____

Parent/Guardian Signature Date

RECOMMENDED PROCEDURE FOR

# Medication Administration in School

Parents are encouraged to administer medication to their students before and/or after school hours. Prescriptions may be given at school only by trained staff. Parents ** are responsible for bringing the medication to the school office.

Medication will not be administered unless accompanied by written parental consent OR student (who meets eligibility requirements**) consent, appropriate instructions (see specific criteria listed below).
Verbal requests to change medication amounts, frequency, or administration times cannot be accepted (unless by a physician to a licensed nurse).

## Prescription Medication:

- Requires written instruction from a physician. The prescription label meets this requirement.
  Any changes in instructions (e.g. dosage or frequency) must also be per a physician written order.
- Requires written parent or guardian permission**.
- The medication must be in the original pharmacy container.


**Medications**

- may only be given as ordered by the physician on the prescription container.
- May be given within the 30 minute 'window' before or after the prescribed time.
- Can not be dispensed at alternate times to accommodate early releases from school and/or classes.

- The school may not give the student medication not normally dispensed during school hours because the dose was missed at home.
- Verbal physician orders can only be taken by a licensed nurse.

## Non-prescription Medication:

Limited to eyes, nose and cough drops, cough suppressants, analgesics, decongestants, antihistamines, topical antibiotics, anti-inflammatories and antacids that do not require written or oral instructions from a physician.

- Requires written parent or guardian permission **which includes the following information:
  - Student Name
  - Name of medication
  - Dosage (per manufacturer's recommendation)
  - Route
  - Frequency of administration
  - Other special instruction (e.g. purpose for medication – symptom specific)
  - Signature of parent / guardian**
- Must be commercially prepared and FDA approved (if not, it requires a prescription)
- Non-alcohol based
- Necessary for student to remain in school
- Must be in the original container or packaging with manufacturer's recommended dosage schedule included.

## Student Self Medication:

If a student has a medical condition that necessitates he/her person, both a signed parent permission form and a signed statement by the physician shall be on file in the school.
The student may have in his/her possession only the amount necessary for that school day.
****Unless the student meets the age of consent eligibilities as outlined in ORS 109.610, 109.640 or 109.675****

## PLEASE KEEP ILL STUDENTS OUT OF SCHOOL

The list below gives school instructions, not medical advice. Please contact your health care provider with health concerns. **During 2020-2021, anyone exposed to COVID-19 must stay home for 14 days.**

| SYMPTOMS OF ILLNESS | THE STUDENT MAY RETURN AFTER…<br>*The list below tells the shortest time to stay home.<br>A student may need to stay home longer for some illnesses. |
|---|---|
|  **Fever**: temperature of 100.4°F [38°C] or greater | ***Fever-free for 24 hours** without taking fever-reducing medicine **AND** after a COVID-19 **test is negative**, OR **10 days** if not tested. |
|  New **cough** illness **OR**<br>New **difficulty breathing** | ***Symptom-free for 24 hours AND** after a COVID-19 **test is negative**, OR **10 days** if not tested.<br>If diagnosed with pertussis (whooping cough), the student must take 5 days of prescribed antibiotics before returning. |
|  **Headache** with stiff neck or with fever | ***Symptom-free OR** with orders from doctor to school nurse. Follow fever instructions if fever is present. |
|  **Diarrhea**: 3 loose or watery stools in a day **OR** not able to control bowel movements | ***Symptom-free for 48 hours OR** with orders from doctor to school nurse. |
|  **Vomiting:** one or more episode that is unexplained | ***Symptom-free for 48 hours OR** with orders from doctor to school nurse. |
| **Skin rash** or **open sores** | ***Symptom free**, which means rash is gone OR sores are dry or can be completely covered by a bandage **OR** with orders from doctor to school nurse. |
| **Red eyes with eye discharge**: yellow or brown drainage from the eyes | ***Symptom-free**, which means redness and discharge are gone **OR** with orders from doctor to school nurse. |
| **Jaundice**: new yellow color in eyes or skin | ***After the school has orders** from doctor or local public health authority to school nurse. |
| **Acting different without a reason**: unusually sleepy, grumpy, or confused. | ***Symptom-free**, which means return to normal behavior **OR** with orders from doctor to school nurse. |
| **Major health event**, like an illness lasting 2 or more weeks OR a hospital stay. | ***After the school has orders** from doctor to school nurse. |
| **Student's health condition requires more care than school staff can safely provide** | ***After measures are in place** for student's safety. |

Oregon Health Authority

OREGON DEPARTMENT OF EDUCATION

Welcome back students to the 2022-23 School year,

The attached application is for Willamina and Sheridan School District Students who are enrolled members of the Confederated Tribes of Grand Ronde or any other Federally Recognized Tribe, or who are descendants of a Federally Recognized Tribe. This application will be necessary to access services through the CTGR Youth Education Program. We are continuing to define what services will be available for the 2021/2022 School Year, but at a minimum, it will include academic support for students.

For further information or if you have questions, please contact the Youth Education Department at 503-879-2102

For Office

**Received**_____

## The Confederated Tribes of Grand Ronde
## K-12 Youth Education Department Program Application
### Authorization for Release of Information

I, the undersigned, hereby request and authorize the following agencies and programs to release information to the Confederated Tribes of Grand Ronde (CTGR) Education Division to document eligibility for program services and to provide and coordinate services to my student(s).

| Name of Student(s): | Date of Birth: | Grade: | Tribal Affiliation |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**I authorize the following agencies and programs to exchange information and coordinate services for my child:**

**CTGR Education Division**
**CTGR Social Services/Prevention**
**CTGR Health and Wellness**
**CTGR Tribal Court**
**Educational Institution(s)**
**CTGR Member Services**
**CTGR Human Resources**
**CTGR Land and Culture**
**Grand Ronde Tribal Housing Authority**

**Please list any agencies you would NOT want Youth Education to share information with:**

**Authorization for the agencies and program above includes, but is not limited to:**

- **Academic records/administrative records that includes class schedules, current grades, grade point average, grade level, class ranking, aptitude, test results, and assignments • Individualized Education Program or Multidisciplinary Team process and results**
- **Attendance records including absences and tardiness.**
- **Medical, physical, or health related records including mental, environment, social, and behavioral reports**
- **I authorize my student(s) image may be taken and used for publication including Smoke Signals, social media, CTGR employee emails, advertisements, and the grandronde.org website**
- **I authorize my student to be transported by CTGR vehicle**
- **I agree that a photocopy or fax copy of this form is acceptable with the same authority as the original**

***This authorization will be in effect from _____to _____ or until revoked in writing.

Please note: you will need to print this form and hand-write your signature prior to submitting to YED

_____ _____ _____ **Signature of Parent/ Legal**
**Printed Name of Parent/Legal Guardian** **Date**

_____ _____ _____ _____
**Mailing Address** **City** **State** **Zip**

_____ _____ _____ _____
**Phone Number** **Email** **Emergency Contact** **Phone**

**Preferred Method of Contact:** ☐ **Phone** ☐ **Text** ☐ **Email** ☐ **Mail**

For Office

**Received**_____