Clarinda Community School District
Enrollment/ Emergency Form

Student_____ Grade_____ Date of Birth_____ Male/Female_____

Home Phone_____ Address_____City,State,Zip_____

Family Information:

List Name and Relationship to child:	Address	Home Phone	Cell Phone	Employer	Work Phone	Email address	Has contact with student Yes/No
Parent/Guardian Living with Student:							
Spouse of Parent/Guardian Listed Above:							
AND							
Parent/Guardian Not Living with Student:							
Spouse of Parent/Guardian Listed Above:							

Please Mark if student: is **Open Enrolled** Yes/ No in **Band** Yes/ No If Yes, list instrument _____ in **Special Education** Yes/ No has a **504 plan** Yes/No

Student lives with: __Parent(s) __Caretaker __Legal Guardian **Student lives in:** __Parent home __Relatives/Friends home __Hotel __Other

Contact Information (please list LOCAL contacts):

Ask about texting notifications!

Child Care_____ Child Care Phone_____

Emergency Contact #1_____ Phone (1) _____ Phone (2) _____

Emergency Contact #2_____ Phone (1) _____ Phone (2) _____

Emergency Contact #3_____ Phone (1) _____ Phone (2) _____

For Residents New to Clarinda: What Brought You to Clarinda: ___Employment ___Relatives ___Other - please list _____

School Medical Registration Form – Health History

Please list a local provider that you prefer in the case of an emergency.

Family Doctor _____ Date of last exam _____ Does student have a current school physical Y/N

Dentist _____ Date of last exam _____

Eye Doctor _____ Date of last exam _____

***In the event of an emergency, 911 will be called and your child will be taken to Clarinda Regional Health Center.**

List other doctors, specialists, counselors (local or out-of-town): _____

Allergies (list allergy and type of reaction): _____

Medications taken routinely: _____

Will your child take medicine at school: Yes/No If yes, what medication? _____

* Note- All medications given at school must be supplied by the parent in the original container and a medication permit form must be completed and signed by the parent.

1. Does your child have health insurance? Yes/No Provider Name: _____

2. Do you have any concerns about your child's general health? (eating, sleeping, weight, etc.) Yes/No

3. Does your child have any chronic illness or medical condition? (seizures, asthma, heart condition, ADHD, etc.) Yes/No

4. Has your child had any serious accidents? (burns, head injury, broken bones, etc.) Yes/No

5. Does your child have any problems with:

Hearing	Yes/No	Vision	Yes/No	Does your child wear glasses?	Yes/No
Speech	Yes/No	Physical Disabilities	Yes/No		

Explain all yes answers in the space provided below:

_____

_____

_____

This form will be added to the student's health file and shared with appropriate school staff.

Parent Signature: _____*Date:* _____

605.6E1 Internet Access Permission Letter

Dear Student, District Personnel or Volunteer/Other:

As part of the School District's continuing effort to provide all students, employees and volunteers with high quality, up-to-date educational resources, we have internet access on the computers in all Clarinda Community Schools.

Please know the entire administration and staff of the school district is committed to ensuring the use of computers and internet access for only educationally sound and productive learning activities. During school activities teachers and other staff will guide students toward appropriate materials.

The School Board has adopted a Responsible Use Policy to comply fully with the federal Children's Internet Protection Act. Each school will review the information in the District Computer, Network and Internet Policy in age-appropriate language before allowing him/her to use the Internet on a school computer. We also request that you review the policy with your child to reinforce the importance of internet safety for all children. One rule that we consistently emphasize is that students, employees and volunteers should never give out personal information (home address, phone numbers, etc.) about themselves or others when using the internet.

I understand, accept and agree to abide by the following terms and conditions:

- I have received and familiarized myself with the District Computer, Network and Internet Policy approved by the Clarinda Community School Board.
- I will abide by the Terms and Conditions of the District Computer, Network and Internet Policy in my use of computing devices at school.
- I understand and accept that the purpose of the Clarinda Community Schools network is educational, and other uses are inappropriate.
- I understand and accept that the use of the School Community Schools network is a privilege and not a right.
- I understand that there is no guarantee of privacy using District technology.
- I understand that violation of the District Computer, Network and Internet Policy may result in disciplinary action ranging from a verbal or written warning to criminal prosecution.
- I understand that if it is determined that a device is lost or damaged as a result of my negligence, that I am responsible for the cost to replace or repair the device.

I have read Policy 605.6 Internet Acceptable Use and Policy 605.6E1 Internet Access Permission Letter and agree to abide by these provisions. I understand that violation of these provisions may constitute suspension or revocation of internet privileges and discipline. School personnel who violate these provisions may be subject to disciplinary action including immediate discharge or termination of employment.

This agreement will be in effect for as long as the student, employee or volunteer/other attends, is employed, volunteers, or participates at Clarinda Community School District and may be revoked at any time by the parent/guardian or administration. Procedures are subject to change at any time at the discretion of the superintendent.

Reference Policy 605.6

Date:
Student
Print Student Name:
Student Signature:
Parent
Print Parent/Guardian Name:
Signature Parent/Guardian:

Iowa Department of Public Health
CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent or Guardian Name:	Telephone (home or mobile):	
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: ☐ Male ☐ Female

Screening Information (health care provider must complete this section)

Date of Dental Screening: _____

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

☐ **No Obvious Problems** – the child's hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ **Requires Dental Care** – tooth decay[1] or a white spot lesion[2] is suspected in one or more teeth, or gum infection[3] is suspected.

☐ **Requires Urgent Dental Care** – obvious tooth decay[1] is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

[1] Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.
[2] White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.
[3] Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check ONE only):
☐ DDS/DMD ☐ RDH ☐ MD/DO ☐ PA ☐ RN/ARNP (High school screen must be provided by DDS/DMD or RDH)

Provider Name: (please print) _____ Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider or Recorder*: _____ Date: _____

*Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, or RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health • Oral Health Bureau
515-281-3733 • 866-528-4020 • www.idph.state.ia.us/hpcdp/oral_health.asp
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

ETHNICITY/RACE

Student Name: _____

Is this student Hispanic/Latino? (*Choose only one*)

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino** (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)

The above part of the question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate what you consider your student's race to be.

What is the student's race? (*Choose one or more*)

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other 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.)

_____

Signature

School District: _____ Date completed: _____

Migrant Education Parent Form

The answers to this form will help determine if your child (ren) is eligible to receive supplemental services from the Migrant Program.

Name of Parent(s) or Legal Guardian(s)		
Current Address: City:	State:	Zip Code:
Phone Number:		
Best Time to be Contacted:		

1. Has your family moved in order to work in another city, country, or state in the last three (3) years YES___ NO____
2. If so, what is the date your family arrived in the city/town? _____
3. Has anyone in your family been involved in one of the following jobs, either full or part-time or temporarily during the last three (3) years? (Check all that apply)

   [ ] Agriculture; planting/picking fruits and vegetables
   [ ] Planting, Growing, Detasseling or Farm labor
   [ ] Processing/packing agricultural products
   [ ] Dairy/Poultry/Egg/Livestocks
   [ ] Meatpacking/Meat processing
   [ ] Fishing or fish farms
   [ ] Other (Please specify the job):_____

4. Name of student(s) Name of School Grade

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Thank you!

Please return this form to the school. Note for the school/district: When both "yes" to #1 and one or more of the boxes from #3 is/are checked, please give this form to the migrant liaison to scan and email to alex.johnson@iowa.gov. Please file original in student's records. For additional questions regarding this form, please contact Geri McMahon at 515-2813944 (geri.mcmahon@iowa.gov) or Susan Selby at 515-281-4732 (susan.selby@iowa.gov) .

Clarinda School District
Home Language Survey

Date_____ School _____Grade_____

Student Name: _____
(last) (first) (middle)

*Place of Birth: _____

Father/Guardian Name: _____

*Employment: _____

Mother/Guardian Name: _____

*Employment: _____

Address: _____

Phone Number : _____ (home) _____(work)

1. Was English the first language your son/daughter learned to speak? _____Yes _____No

2. What language do you speak to your son/daughter? (father) _____

(mother) _____

3. What language does your son/daughter speak to you? _____

4. What language does your son/daughter speak to other relatives? _____

5. What language does your son/daughter speak to friends? _____

6. In what language would you prefer to receive

communication from the school? _____

I understand my son/daughter, _____, will receive English language proficient testing. I will be notified if my son/daughter qualifies for English Language Learner (ELL) program services. I understand that at the time I have the right to refuse ELL services for my child. However, I can request services at a later date.

_____ _____
(Parent/Guardian Signature) (Date)

OFFICE USE ONLY: Refer for:

Initial ELL Identification: _____ Initial Migrant Identification: _____

MILITARY CONNECTED STATUS

Revised 10/24/13

STUDENT NAME:

CHECK ONE

- ◯ **Neither Parent or Guardian is serving in any military service**
- ◯ **A Parent or Guardian is serving in the National Guard but is not deployed**
- ◯ **A Parent or Guardian is serving in the Reserves but is not deployed**
- ◯ **A Parent or Guardian is serving in the National Guard and is currently deployed**
- ◯ **A Parent or Guardian is serving in the Reserves and is currently deployed**
- ◯ **A Parent or Guardian is serving in the military on active duty but is not deployed**
- ◯ **A Parent or Guardian is serving in the military on active duty and is currently deployed**
- ◯ **The student's Parent or Guardian died while on active duty within the last year**

COMMENTS: _____

_____

_____

_____

_____

NEW STUDENT FORM
TAG DETERMINATION

Date _____

New Student Name_____

Grade_____

Last School Attended_____

City, State_____

Parent's Name_____

Office Use Only

Iowa Assessment/State Assessment Scores

Year	Reading	Math	Science
_____	_____	_____	_____
_____	_____	_____	_____

☐ Office

☐ Guidance

☐ TAG

Clarinda Regional Health Center

CONSENT FOR ATHLETIC TRAINING SERVICES
EMERGENCY MEDICAL TREATMENT

RETURN TO THE: _____

Student's Name:_____ Date of Birth:_____

Student's Address:_____ City:_____

Parent (Guardian) Name: _____

Home Phone: _____

Father: Work Phone _____ Cell: _____

Mother: Work Phone_____ Cell: _____

In case of emergency and the absence of parent/guardian, please list two people you recommend we call:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

List any known allergies: _____

List any medications student is taking and why: _____

List any physical disabilities: _____

Additional Comments: _____

Name of Medical Insurance Company or Plan: _____

Policy Number(s): _____

Health Maintenance Organization (HMO)? Yes _____ No _____

If yes, what is your primary care facility: _____

CONSENT & AUTHORIZATION

I hereby authorize the employed or contracted staff of Clarinda Community High School Athletic Department ("Department") (i.e., administrators, coaches, athletic trainers, team physician, and/or other assigned medical personnel) to provide athletic training services to my son/daughter/ward and to secure any necessary medical assistance on behalf of my son/daughter/ward. I further authorize these individuals to discuss my son/daughter/ward's medical condition with other health care personnel, which the Department deems appropriate. To the fullest extent permitted by law, I do hereby indemnify and hold harmless the Department, entities, and other persons who act in reliance upon this authorization. This document is valid for all years of student's enrollment at Clarinda Community High School. Any changes to above information needs to be made with the athletic trainer and is up to the responsibility of the parent/guardian.

Parent/Guardian Signature:_____ Date: _____

Student (if 18 years old) Signature:_____ Date: _____