

Student Name _____

Cordell Secondary School

7th Grade

Schedule Pick-up Checklist

2018-2019

Welcome to Cordell Secondary School.

To expedite your enrollment process, please complete this entire enrollment packet and bring it to the Secondary Enrollment Session either Thursday, August 9th from 9:00 am – Noon or Monday, August 13th from 5:00 pm – 7:00 pm in the JH/HS Cafeteria. Parents will not be required to attend, but all forms must be completed before students will receive their schedules.

Teacher/Staff Initials

Lunch Form

Only 1 Form is Required per Household

Medical Forms

Authorization for Medical Care of a Minor
Health History
Concussion/Cardiac Forms for Athletics

Complete Packet

Registration Information
Drug Testing Consent Form
Home Language Survey

Laptop Packet & Fee

You will receive your schedule when the above steps are complete and all areas are initialed by a staff member.

Thank you and have a great year!
Angela Caler, Counselor

Cordell Secondary School **2018 - 2019**

Student's Legal Name: _____ Grade: _____

Preferred Name: _____ Home Phone: _____

Mailing Address: _____ County: _____

Street Address (if different from mailing): _____ Student's Cell: _____

Date of Birth: _____ Birth Place: _____ SSN: _____

Gender: M or F Ethnicity: Are you of Hispanic/Latino culture or origin ? (Yes or No)

What is your race? (Choose one or more) American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White

Student is living in transportation area _____ over 1.5 miles _____ under 1.5 miles to school.

Last School Attended (if not Cordell): _____ Date Withdrawn: _____

If student attended another school, did he/she receive special services (Special Education, Speech, Physical Therapy, Gifted/Talented, etc)? _____ If yes, please list _____

Father: _____ Place of Employment: _____

Mailing Address, City, State, Zip (if different from student): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Mother: _____ Place of Employment: _____

Mailing Address, City, State, Zip (if different from student): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Guardian (if other): _____ Place of Employment: _____

Mailing Address, City, State, Zip (if different from student): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Relationship to Student: _____

Parent/Guardian E-Mail Address: _____

In case of an emergency and we are not able to reach you, we need the names of those you give authorization to pick up your child in case of illness or injury.

1. Name _____ Phone: _____ Relationship to Student: _____
2. Name _____ Phone: _____ Relationship to Student: _____
3. Name _____ Phone: _____ Relationship to Student: _____

Student's Doctor: _____ Phone: _____

Please list full names and grades of other family members currently attending Cordell Public Schools who reside with you: _____

STUDENT INFORMATION

Name of Student: _____ Grade: _____
 Last Name First Name Middle Name

Date of Birth: _____ School: _____ Student ID # _____ Gender: Male _____ Female _____
 MM/DD/YYYY

Is the student of Hispanic or Latino culture or origin? Yes _____ No _____

Select one or more of the following races:

_____ African American/Black _____ American Indian/Alaskan Native _____ Asian
 _____ Native Hawaiian/Pacific Islander _____ Caucasian/White

1. What is the dominant language **most often** spoken by the student? _____
2. What is the language **routinely** spoken in the home, regardless of the language spoken by the student? _____
3. What language was **first** learned by the student? _____
4. Does the parent/guardian need **interpretation** services? Yes _____ No _____ If so, what language? _____
5. Does the parent/guardian need **translated** materials? Yes _____ No _____ If so, what language? _____
6. What was the date the student first enrolled in a school in the United States? _____
 MM/YYYY

_____ Date (MM/DD/YYYY)

_____ Parent / Guardian Signature

SCHOOL USE ONLY

Please have test score documentation available for the Regional Accreditation Officer to review.

- Other language than English indicated TWO OR MORE times on questions 1 – 3 above.** The student is classified as “more often” and automatically qualifies as **bilingual** on the accreditation report.
- Other language than English indicated ONLY ONCE on questions 1 – 3 above.** The student is classified as “less often” and only qualifies as **bilingual** on the accreditation report **if he or she meets one of the following** (any selection below REQUIRES appropriate documentation):
 - 1. Designated English Learner on one of the Oklahoma English language proficiency assessments: ACCESS for ELLs 2.0, Alternate ACCESS for ELLs, WIDA Screener, WIDA MODEL, K-WAPT, W-APT or Oklahoma Pre-K Language Screening Tool.
 - 2. Scored unsatisfactory or limited knowledge in Reading on the Oklahoma State Testing Program (OSTP).
 - 3. Scored at or below the 35th percentile (or equivalent) composite reading score from spring of the previous school year on a state approved norm-referenced test (NRT).

DOCUMENTATION OF A TEST RESULT FOR STUDENTS MARKED LESS OFTEN

Date(s) of Kindergarten ACCESS, ACCESS for ELLs 2.0, or Alternate ACCESS Test	Score(s) on Kindergarten ACCESS, ACCESS for ELLs 2.0, or Alternate ACCESS		Date(s) of WIDA Screener or K-WAPT/WAPT or WIDA MODEL	Score(s) on WIDA Screener or K-WAPT/WAPT or WIDA MODEL	
	Composite Score	Literacy Score		Composite Score	Literacy Score
	1.	2.		1.	2.
	1.	2.			

Date(s) of Reading OSTP	Score(s) on Reading OSTP			
	Unsatisfactory	Limited Knowledge	Satisfactory	Advanced
	Unsatisfactory	Limited Knowledge	Satisfactory	Advanced
	Unsatisfactory	Limited Knowledge	Satisfactory	Advanced

Date of the Oklahoma Pre-K Language Screening Tool	Score on Pre-K Language Screening Tool
	%

Date(s) Norm Reference Test (NRT)	Name of the NRT	Reading Total Composite Score(s) %

From Above:
 Question 1: Reference WAVE code 1036
 Question 2: Reference WAVE code 1037
 Question 3: Reference WAVE code 1038

CORDELL BOARD OF EDUCATION
2018-2019 DISTRICT STUDENT DRUG TESTING CONSENT FORM

Statement of Purpose and Intent

Participation in school sponsored extra-curricular activities at the Cordell School District is a privilege not a right. Activity Students carry a responsibility to themselves, their fellow students, their parents and their school to set the highest possible examples of conduct, which includes avoiding the use or possession of illegal drugs.

Drug use of any kind is incompatible with participation in extra-curricular activities, on behalf of the Cordell Public School District. For the safety, health and well being of the student of the Cordell Public School District, the Cordell Public School District has adopted the attached Activity Student Drug Testing Policy and the Student Drug Testing Consent Form for use by all participating students at the Junior High and High School levels.

Participation In Extracurricular Activities

The student, parent or custodial guardian shall be provide with a copy of the Activity Student Drug Testing Policy and Student Drug Testing Consent, which shall be read, signed and dated, by the coach/sponsor before such student shall be eligible to practice or participate in any extracurricular- activities. The consent requires the activity student to provide a urine sample: a) as part of the student's annual physical or for eligibility for participation; b) as chosen by the random selection basis; and c) at any time requested based on reasonable suspicion to be tested for illegal or performance-enhancing drugs. No student shall be allowed to practice or participate in any activity governed by the policy unless the student has returned the properly signed Student Drug Testing Consent.

Student's Last Name _____ First Name _____ MI _____ Grade _____

I understand after having read the "Student Activity Drug resting Policy" and "Student Drug Testing Consent", that out of care for my safety and health, Cordell Public School District enforces the rules applying to the consumption or possession of illegal and performance- enhancing drugs. As a member of a Cordell extra-curricular activity, I realize that the personal decision that I make in regard to the consumption or possession of illegal or performance-enhancing drugs may affect my health and well being as well as the possible endangerment of those around me and reflect upon any organization with which I am associated. If I choose to violate school policy regarding the use or possession of illegal or performance-enhancing drugs any time while I am Involved in in-season or off-season activities, I understand upon determination of that violation I will be subject to the restrictions on my participation as outlined In this Policy

Signature of Student _____ Date _____

We have read and understood the Cordell Public School District "Activity Student Drug Testing Policy" and "Student Drug Testing Consent'. We desire that the student named above participate in the extra-curricular interscholastic programs of the Cordell Public School District and we hereby voluntarily agree to be subject to its terms. We accept the method of obtaining urine samples, testing and analysis of such specimens, and all other aspects of the program. We further agree and consent to the disclosure of the sampling, testing and results provided in this program.

Signature of Parent or Custodial Guardian _____ Date _____

BELOW PLEASE OBTAIN THE SIGNATURES OF ALL COACHES SPONSORS FOR EXTRA-CURRICULAR Activities TEAMS, ORGANIZAT/ONS IN WHICH YOU ARE INVOLVED:

_____ <i>Signature of Sponsor or Coach</i>	_____ <i>Activity, Team, Organization</i>
_____ <i>Signature of Sponsor or Coach</i>	_____ <i>Activity, Team, Organization</i>
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_____ <i>Signature of Sponsor or Coach</i>	_____ <i>Activity, Team, Organization</i>
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_____ <i>Signature of Sponsor or Coach</i>	_____ <i>Activity, Team, Organization</i>
_____ <i>Signature of Sponsor or Coach</i>	_____ <i>Activity, Team, Organization</i>
_____ <i>Signature of Sponsor or Coach</i>	_____ <i>Activity, Team, Organization</i>

CORDELL PUBLIC SCHOOLS

AUTHORIZATION FOR MEDICAL CARE OF A STUDENT

I, _____, the undersigned parent or person having legal custody or the
(please print name of parent having legal custody or legal guardian)

legal guardian of _____ do hereby give consent to any x-ray examination,
(please print student's name)

anesthetic, medical, surgical or dental diagnosis treatment and hospital care to be rendered to the above name student under general or special supervision and upon the advice of a physician, surgeon or dentist licensed under the laws of the State of Oklahoma.

IN GIVING CONSENT, I recognize and understand that in situations where the above student requires immediate medical or hospital care it may not be possible to contact me, and that in such situations I will not be able to knowledgeably evaluate and choose among the available alternative treatments or procedures, if any, or to evaluate the risks attendant upon each, and the risks attendant to foregoing all treatment; in such situations, I authorize a physician, surgeon or dentist to exercise his professional judgment and assess the risks incident to and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he in his professional judgment determines to be necessary for the health or safety of the above named student. In case of an emergency, I authorize officials to seuvre the use of an ambulance, if necessary, for transporting my child to the hospital. I authorize school personnel to provide first aid or medical treatment to my child in the event of an injury occurring during school hours or school functions.

TREATMENT INFORMATION:

Student's Date of Birth: _____ Date of Student's Last Tetanus Shot: _____ Student's SSN: _____

Student's Doctor: _____ Doctor's Phone Number: _____

MEDICAL INFORMATION: circle one. If YES, give needed information.

Heart condition or disease	YES NO	Asthma	YES NO	If YES, list: _____
Diabetes	YES NO	Allergic to medication	YES NO	If YES, list: _____
Convulsions disorder	YES NO	Allergic to insect stings	YES NO	If YES, list: _____

Allergies: _____

Medicine Student is currently taking: _____

Student's Medical History: _____

Circle: Insurance / Medicaid / None Insurance/Medicaid Policy Number: _____

Insurance Company Name: _____

Signature: _____ Date: _____
(Parent or person having legal custody or legal guardian)

Address: _____ Phone number (Cell): _____

_____ Phone number (Work): _____

_____ Phone number (Home): _____

CORDELL PUBLIC SCHOOLS
School year 2018-2019

HEALTH HISTORY AND MEDICAL TREATMENT CONSENT FORM

**Please give all information requested as completely as possible, N/A-if doesn't apply
##If information changes during this school year, please notify the office or nurse.

THIS IS A TWO PAGE DOCUMENT. PLEASE COMPLETE BOTH PAGES

Personal Information

Student's Name _____ Today's Date _____
Male Female (circle) (First) (Middle) (Last) Name goes by _____
Grade _____ Date of Birth _____ Social Security Number _____
Mother _____ Father _____ Guardian _____
Home Phone _____ Work Phone _____ Cell/Mssg. Phone _____
Address _____
Street or P.O.Box _____ City, State _____ Zip Code _____
E-Mail _____
Insurance/Medicaid/None (circle) Insurance Company _____

Medical Information

Doctor/Nurse Practitioner/PA Name _____ Office Location _____
Allergies (food, medication, pets, environment) _____
Glasses/contacts? Date of: **Last Eye Exam** _____ **Last Dental Exam** _____ **Last Tetanus Shot** _____
Illnesses/Hospitalizations (include dates) _____
Medical problems **requiring monitoring** (ADHD, asthma, autism, behavioral, diabetes, seizures) _____

HEALTH SCREENINGS

Throughout the year, any of the following screenings may be provided to the students of Cordell Schools:

Vision, Hearing, Height, Weight, BMI, Dental Hygiene, Blood Pressure, Temperature, Pulse, Head, Neck
There will be **NO COST** for these screenings. Parents will be notified of abnormal findings. Written notification must be provided by the parent/guardian if you do not consent to any of these screenings.

CONSENT FOR MEDICAL TREATMENT

In the event of illness or injury, every attempt will be made to contact you to inform you of your child's condition, and to obtain your directions and consent for treatment. However, if you are unable to be reached, please provide the names and current phone numbers of two people who may be authorized to pick up your child or give consent for treatment by school personnel in your absence.

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

*****Only the people listed above will be permitted to pick up your child without consent from you.**

Please initial the choices below that indicate how care should be given to your child if injury or illness occurs.

(initial) _____ I hereby authorize Dr. _____ or any other physician, surgeon or dentist to administer any emergency treatment, procedure or medicine deemed necessary or advisable. In case of an emergency occurring while the student is away from the immediate vicinity, I authorize officials to secure the use of an ambulance, if necessary, for transporting my child to the hospital. I further agree to pay for the hospital, doctors and ambulance service and for all services rendered to my child.

(initial) _____ I hereby authorize designated school personnel to provide first aid or medical treatment, as indicated, to my child in the event of an injury occurring during school hours or school functions.

(initial) _____ **I do not** consent to the above medical care for my child. Please give specific instructions for what you wish to be done if your child becomes seriously ill or injured and we are unable to reach you.

Parent/Guardian Signature X _____ Date signed _____

Policy FFACA-E2

PARENTAL AUTHORIZATION TO ADMINISTER MEDICINE

TO: _____
(Principal)

(School)

I am the parent with legal custody, the legal guardian, or individual assuming permanent care and custody of _____, a student attending this school. This student requires medication at intervals during the school day.

I hereby give my consent and authorize and request the school principal, or _____
(an employee of the school district designated by the principal, and me) to:

_____ Administer _____, a non-prescription medication that I am hereby supplying you, in accordance with the written instructions of the child's physician that is attached hereto.

_____ Administer _____, a filled prescription medication that I am hereby supplying you, in accordance with the directions for the administration of the medicine listed on the label of the vial.

_____ Administer _____, a filled prescription medication that I am hereby supplying you, in accordance with the written instructions of the physician prescribing the medicine, which is attached hereto.

_____ Permit the student to retain the medication on the student's person since the medication must be administered at unpredictable intervals throughout the day. A physician's statement that the student is capable of, and has been instructed in the proper method of, self-administration of medication is attached.

I understand that under state law, the board of education, the school district, or the employees of the district shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medicine I have hereby authorized or from the self-administration of medication by the student.

Dated this _____ day of _____, _____.

(Parent with Legal Custody, Guardian, or Individual Assuming Permanent Care and Custody)

(Address)

WITNESS:
