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Last School Attended (if not Cordell): _____ Date Withdrawn: _____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

20____- 20____ **HOME LANGUAGE SURVEY FOR PRE-K-12 SCHOOL DISTRICTS**

OKLAHOMA STATE DEPARTMENT OF EDUCATION — CHAMPION EXCELLENCE

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 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 sevure 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:

_____