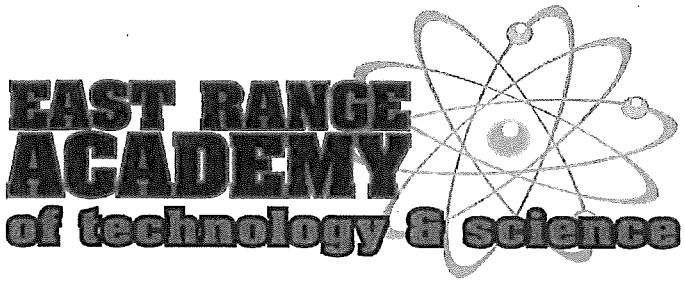


Minnesota Public Charter School #4166

2000 Siegel Boulevard
Executive Director: **Amy Hendrickson**
Dean of Students: **Shane Walters**
Special Education Director: **Jody Youso**
School Secretary: **Candi McKenzie**

Eveleth, MN 55734
Phone Number: **218-744-7965**
Fax Number: **218-744-2349**

Request for Official Educational Information

Date: _____

Education information is requested for _____

Student birthday _____

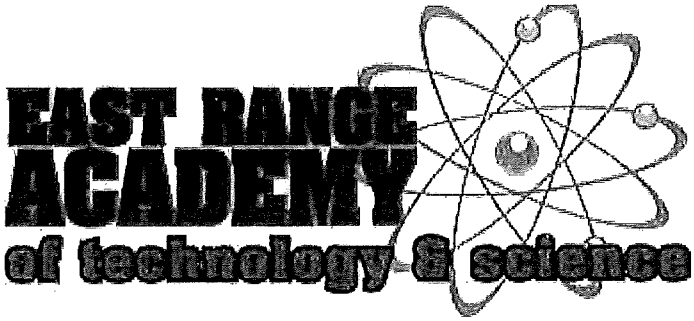
Last school attended _____Current Grade_____

Please release the Official Educational Record of the above student, including:

Transcript of subject and grade
Attendance record
Health & Immunization records
Standardized test results
Psychological test results
Special education records
Basic standards test results
State ID #

Please send records to:
East Range Academy; 2000 Siegel Blvd; Eveleth, MN 55734
Fax-218-744-2349
E-Mail- cmckenzie@mnerats.org

Please feel free to call 218-744-7965 or email (cmckenzie@mnerats.org) if you have any questions. Thanks for your effort in getting these records to us in a timely manner.



Minnesota Public Charter School #4166

Initial Registration Form 2019-2020

Student Name _____

Student Address _____
City State Zip Code

Birth Date _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian _____

Address _____
City State Zip Code

Home Phone _____ Work _____ Cell _____

Email address _____
(By providing your email address you give ERATS permission to email you information regarding student grades/attendance.)

Parent/Guardian _____

Parent Address _____

Home Phone _____ Work _____ Cell _____

Email address _____
(By providing your email address you give ERATS permission to email information regarding student grades/attendance.)

Grade you will be in 2019-2020 school year _____

Transportation

State law mandates we provide transportation for any student who live within the Eveleth-Gilbert boundaries during regular school days Monday-Friday. We currently provide transportation for other students outside of the district.

Do you need transportation?_____

Do you have any questions or concerns at this time about our program? (Please feel free to share any ideas here, also.)

_____

_____

_____

_____

_____

*Please note that student's transcripts must be received and reviewed before enrollment is complete.

Parent Signature _____Date_____

Thanks so much for your time. Please let us know whenever you have questions or concerns about anything!

DEPARTMENT OF EDUCATION

2019-20 Ethnic and Racial Demographic Designation Form

Student's First Name: _____ Middle Name/Initial: _____ Last Name: _____

Date of Birth: _____ District: _____ School: _____

Schools are required to report ethnicity and race to the state and to the U.S. Department of Education. Because of recent changes to Minnesota state law, Minnesota disaggregates each category into detailed groups to further represent our student populations. Parents or guardians are not required to answer the federal questions **(in bold)** for their children. If you choose not to answer the federal questions **(in bold)**, federal law requires schools to choose for you. This is a last resort—we prefer if parents or guardians complete the form. State questions are labeled as "Optional" and schools will not fill in this information for you.

This information helps improve teaching and learning for everyone and helps us accurately identify and advocate for students currently underserved. The information this form collects is considered private information. You can review the privacy notice to learn more about the purpose of collecting this information, how it will be used and not used, and how the detailed groups were identified. The privacy notice can be found in our *Frequently Asked Questions: Ethnic and Racial Designation Form.*

Is the student Hispanic/Latino as defined by the federal government? The federal definition includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.[1]

[You must select "yes" or "no" to this question.]

○ **Yes** *[If yes, go to Question A.]* ○ **No** *[If no, go to Question 1.]*

Optional Question A: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Guatemalan	☐ Salvadoran	☐ Other Hispanic/Latino
☐ Colombian	☐ Mexican	☐ Spaniard/Spanish/ Spanish-American	☐ Unknown
☐ Ecuadorian	☐ Puerto Rican		

Go to Question 1.

[Select "yes" to at least one of the Questions (1-6) below.]

Question 1: Does the student identify as American Indian or Alaska Native as defined by the state of Minnesota? The state of Minnesota definition includes persons having origins in any of the original peoples of North America who maintain cultural identification through tribal affiliation or community recognition. [This question is needed to calculate state aid/funding.]

○ **Yes** *[If yes, go to Question 1a.]* ○ **No** *[If no, go to Question 2.]*

Optional Question 1a: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Cherokee	☐ Other North American Indian Tribal Affiliation
☐ Anishinaabe/Ojibwe	☐ Dakota/Lakota	☐ Unknown

Go to Question 2.

[1]Federal Register, Vol. 72, No. 202/Friday, October 19, 2007/Notices/59274

Question 2. Is the student American Indian from South or Central America?

○ **Yes** *[Go to Question 3.]* ○ **No** *[Go to Question 3.]*

Question 3. Is the student Asian as defined by the federal government? The federal definition includes persons 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.[1]

○ **Yes** *[If yes, go to Question 3a.]* ○ **No** *[If no, go to Question 4.]*

Optional Question 3a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Chinese	☐ Karen	☐ Other Asian
☐ Asian Indian	☐ Filipino	☐ Korean	☐ Unknown
☐ Burmese	☐ Hmong	☐ Vietnamese	

Go to Question 4.

Question 4. Is the student black or African American as defined by the federal government? The federal definition includes persons having origins in any of the black racial groups of Africa.[1]

○ **Yes** *[If yes, go to Question 4a.]* ○ **No** *[If no, go to Question 5.]*

Optional Question 4a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Ethiopian-Other	☐ Somali
☐ African-American	☐ Liberian	☐ Other black
☐ Ethiopian-Oromo	☐ Nigerian	☐ Unknown

Go to Question 5.

Question 5. Is the student Native Hawaiian or Other Pacific Islander as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.[1]

○ **Yes** *[Go to Question 6.]* ○ **No** *[Go to Question 6.]*

Question 6. Is the student white as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Europe, the Middle East, or North Africa.[1]

○ **Yes** ○ **No**

Parent(s)/Guardian Name _____ Date _____

Parent(s)/Guardian Signature _____

DEPARTMENT OF EDUCATION

District Parent Letter

Dear Parent or Guardian:

In an effort to assist Minnesota districts in providing targeted programs and services to help all students succeed, districts are required by law to request more detailed student ancestry or ethnic origin information based on Minnesota's largest groups, beyond what has been collected on enrollment forms under federal law since 2008. Parents or guardians are not required to answer the federal questions (in bold) on the Ethnic and Racial Demographic Designation Form for their children. However, if you choose not to answer the federal questions (in bold), federal law requires schools to choose for you. State questions are labeled as "Optional" and schools will not fill in this information for you. Refusal to respond will not impact enrollment in the school.

As a result of the new law, you are asked to report your child's information. Starting with the 2019-20 school year, all schools in Minnesota will collect this information using these updated categories. It is likely you will be asked to fill out a revised form next year as well. The Minnesota Department of Education will continue to incorporate feedback from the public into this form.

To report your child's information, please complete the enclosed form and return it to East Range Academy. Note: You may choose to not indicate any of the more detailed selections by marking the "decline to indicate" option(s). You may also choose to mark an "other" option if you do not see your group represented. School staff are not required to assign students to these detailed groups.

Please complete and return the enclosed form. For more information about the reporting categories, please contact Candi McKenzie at 218-744-7965.

Sincerely,

Amy Hendrickson

Minnesota Language Survey

Minnesota is home to speakers of more than 100 different languages. The ability to speak and understand multiple languages is valued.

The information you provide will be used by the school district to see if your student is multilingual. In Minnesota, students who are multilingual may qualify for a Multilingual Seal upon high school graduation. Additionally, the information you provide will determine if your student should take an English proficiency test. Based upon the results of the test, your student may be entitled to English language development services. **Access to services are required by federal and state law. As a parent or guardian, you have the right to decline English Learner services at any time.**

Every enrolling student must be provided with the Minnesota Language Survey during enrollment. Information requested on this form is important to us to be able to serve your student. Your assistance in completing the Minnesota Language Survey is greatly appreciated.

Student Information	
Student's Full Name: (Last, First, Middle)	Birthdate or Student ID:

	Check the phrase that best describes your student:	Indicate the language(s) other than English in space provided:
1. My student first learned:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
2. My student speaks:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
3. My student understands:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	
4. My student has meaningful and consistent exposure to:	___ language(s) other than English. ___ English and language(s) other than English. ___ only English.	

Language use alone does not identify your student as an English learner. If a language other than English is indicated, your student will be screened for English language proficiency.

Parent/ Guardian Information	
Parent/Guardian Name (printed):	
Parent/Guardian Signature:	Date:

* All data on this form is private. It will only be shared with district staff who need the information to best serve your student and for legally required reporting about home language and service eligibility to the Minnesota Department of Education. At the district and at the Minnesota Department of Education, this information will not be shared with other individuals or entities, except if they are authorized by state

May 8, 2017

MEDIA RELEASE FORM

I hereby grant *East Range Academy of Technology and Science* permission to use any or all information obtained from me during the 2019-2020 school year.

I also grant *East Range Academy of Technology and Science* permission to use any photographs or likeness of me taken by *East Range Academy of Technology and Science* photographers.

I understand that information from my interviews and any photos may be used in a story to be published on, but not limited to: the *East Range Academy of Technology and Science's* webpage & Facebook page, online newspaper, or other local & national media outlets.

I understand *East Range Academy of Technology and Science's* publications are distributed both in school, throughout the community, and/or nationally. I also understand that media may be reproduced on the *East Range Academy of Technology and Science* Web site, which can be read by anyone in the world with access to the Internet, and may be available for years to come. I have been advised by *East Range Academy of Technology and Science* staff that, as a minor, I may wish to discuss my decision to consent to such publication with my parents and others whose opinions I respect. I am providing permission to *East Range Academy of Technology and Science* to use my information and photographs of my own free will because I believe others may benefit from knowing of my experiences.

Specifically, my permission includes the following:
(1) The right to publish and republish, at any time, the above information or photos in, but not limited to: the school's newspaper, online publications, Facebook page, on *East Range Academy of Technology and Science* Web site and in any subsequent medium for any noncommercial purpose, including promotion of *East Range Academy of Technology and Science*;
(2) The right of *East Range Academy of Technology and Science* or individual authors or photographers to copyright such information or photographs in their own name;
(3) The right of *East Range Academy of Technology and Science* to use my name in connection with such information or photos if it chooses. I waive any right to inspect or approve the finished story or stories, photographs or other uses of my information that may be published.

In consideration of my participation, I understand that, at my request, *East Range Academy of Technology and Science* will provide me with up to ten copies of any issue that contains information or photographs related to me at no charge.

I hereby release and discharge *East Range Academy of Technology and Science*, its staff members, District #4166 and its employees from any claims and demands arising out of or in connection with the use of the information or photographs described above, including any claims for libel or invasion of privacy.

☐ Yes I give permission ☐ No I do not give permission

I have read the above release prior to signing it and am fully familiar with its provisions.
Student Name (print full name):_____
Parent Signature: _____
Date: _____

EMERGENCY INFORMATION/ 2019-2020

(Please Print) Grade_____

Student Name_____

Last First Middle

Address_____

Street City State Zip

Home Phone (___)_____ Birth Date_____

Email Address_____

Where can parent/guardian be reached if not at home? (work, cell, etc.)

Mother/Guardian_____

First Last Alternate contact number

Father/Guardian_____

First Last Alternate contact number

List 2 other people (neighbors, relatives, etc.) that will be able to pick up your child in case of illness or emergency, and can assume temporary care of your child if you are unable to be reached or cannot get to the school.

1. Name_____
   Relationship to you or your child
   Phone Number_____
2. Name_____
   Relationship to you or your child
   Phone Number_____

Please list any allergies to medications or any other health concerns your child may have:

_____

_____

DEPARTMENT OF EDUCATION

2019-20 Application for Educational Benefits

Complete one application per household. Please use pen (not a pencil).

STEP 1: **List ALL Household Members who are infants, children, and students** up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper).

Definition: A Household Member is "Anyone living with you and shares income and expenses, even if not related." Children in Foster care are eligible for free meals. Read *How to Complete the Application for Educational Benefits* for more information.

Child's First Name	MI	Child's Last name	School	Grade	Birthdate	Foster Child (√)
						☐
						☐
						☐
						☐
						☐

STEP 2: Do Any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, MFIP or FDPIR? Medical assistance **does not** qualify.
If YES >Enter SNAP, MFIP or FDPIR Case Number _____ then go to STEP 4 (Do not complete STEP 3) **If NO** > Go to STEP 3.

STEP 3: Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

A. **Child Income**
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all children listed in STEP 1.

Child Income	Weekly	Bi-weekly	2x Month	Monthly
$	☐	☐	☐	☐

B. **All Adult Household Members (including yourself).** For each Household Member listed, if they do receive income, report total gross income only. If they do not receive income from any source, write '0' or leave any fields blank. You are certifying (promising) that there is no income to report.

Not sure what income to include here? Flip the page and review "Sources of Income" for information. "Sources of Income" will help you with the Child Income section and All Adult Household Members section.

Name of Adult Household Members (First and Last) List all Household members not listed in STEP 1 (including yourself) even if they do not receive income. Include children who are temporarily away at school or in college.	Weekly	Bi-Weekly	2x Month	Monthly	Gross earnings from Work Report income before deductions or taxes, for each source in whole dollars (no cents).	Monthly	Yearly	Net income from Self-Employment	Weekly	Bi-Weekly	2x Month	Monthly	All Other Gross Income such as SSI, Unemployment, Public Assistance, Child Support, and others on Page 2
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$

C. **Last Four Digits of Social Security Number (SSN)** of Primary Wage Earner or Other Adult Household Member XXX-XX-_____ Check if **no SSN:** ☐ **Total Household Members** (Children and Adults) _____

STEP 4: Contact information and adult signature. Mail or return completed form to: (*School/District Information*) Sign here :

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is give in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

☐ I have checked this box if I *do not* want my information shared with Minnesota Health Care Programs as allowed by state law.

Printed name of adult signing form Daytime Phone

Street Address (if available) Apt# City Zip

Signature of Household Adult Date

Do not fill out: For School Use Only

Annual Income Conversion:
Weekly x 52
Bi-Weekly x 26
Twice a Month x 24
Monthly x 12

All Total Income (Include child and adult income)	Weekly	Bi-weekly	2X Month	Monthly	Annualize	Household Size	Categorical Eligibility	Free	Reduced	Denied
$	☐	☐	☐	☐	☐		☐	☐	☐	☐

☐ Selected for Verification – attach Verification Tracker

Determining Official's Signature Date

Confirming Official's Signature Date

*=must complete!

INSTRUCTIONS: Sources of Income

Sources of Income for Children

Sources of Child Income	Examples
• Earnings from work • Social Security a. Disability Payments b. Survivor's Benefits • Income from person outside the household • Income from any other source	• A child has a regular full or part-time job where they earn a salary or wages • A child is blind or disabled and receives Social Security • A Parent is disabled, retired, or deceased, and their child receives Social Security benefits • A friend or extended family member regularly gives a child spending money • A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	All Other Income
• Salary, wages, cash bonuses (before deductions or taxes) • Net income from self-employment (farm or business) • If you are in the U.S. Military: a. Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) b. Allowances for off-base housing, food and clothing	• Cash Assistance from State or local government • Supplemental Security Income • Unemployment benefits • Worker's compensation • Alimony payments • Child support payments • Veteran's benefits • Strike benefits	• Social Security • Disability benefits • Regular income from trusts or estates • Annuities • Investment income • Rental income • Regular cash payments from outside household

OPTIONAL: Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

At public school districts, each student's school meal status also is recorded on a statewide computer system used to report student data to MDE as required by state law. MDE uses this information to: (1) Administer state and federal programs, (2) Calculate compensatory revenue for public schools, and (3) Judge the quality of the state's educational program.

Nondiscrimination statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, you have two options: 1. Complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at Filing a Program Discrimination Complaint as a USDA Customer, and at any USDA office; or, 2. Write a letter addressed to USDA; provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by one of the following methods:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) Fax: 202-690-7442; or
(3) Email: program.intake@usda.gov

This institution is an equal opportunity provider.

EAST RANGE ACADEMY OF TECHNOLOGY AND SCIENCE 218- 744-7965
2000 SIEGEL BLVD., EVELETH, MN 55734 FAX: 218-744-2349

MEDICATION ADMINISTRATION FORM 2019-20

All prescription and over the counter medications to be given to students at school must be listed on this form, signed by parent for RX and over the counter medications; and by prescribing professional(for prescriptions).

All prescription drugs must arrive in RX bottle labelled with: Date of Rx, Rx number, name of student, name of medication, dose, time to be given, expiration date, prescriber's information

PHARMACIES WILL GIVE A SEPARATE PRESCRIPTION BOTTLE TO BE KEPT AT SCHOOL

All over the counter medications to be given must be sent from home in the original containers with the Student's Name written on it

TYLENOL, IBUPROFEN, ADVIL, MOTRIN, COUGH MEDICINE, COUGH DROPS, ALLEGRA, ZYRTEC, CLARITIN, FLONASE, MIDOL, PAMPRIN, BENADRYL, TUMS, ROLAIDS, PEPTO BISMOL, MILK OF MAGNESIA, ETC.

CONTACT SCHOOL NURSE, CINDY LUSTIG WITH QUESTIONS

218-744-7965 EXT. 1220

clustig@mnerats.org

MEDICATION ADMINISTRATION FORM

STUDENT NAME _____ DATE OF BIRTH _____ GRADE _____

I HEREBY REQUEST AND AUTHORIZE YOU TO GIVE:

	MEDICATION	DOSE	TIME TO BE GIVEN
1.			
2.			
3.			

Diagnosis/medical reason for medication _____

Other medications this student is taking _____

Other recommendations/unusual side effects _____

Physician's name _____ **Physician's signature** _____

Clinic
address_____phone_____fax_____

PARENT/GUARDIAN AUTHORIZATION:

I request that the above medication be given during school hours as ordered by this student's physician.

I release school personnel from any liability in relation to this request when the medication is given as ordered.

I will notify the school of any changes in the medication such as dosage changes, time changes or discontinuation of the medication, and obtain the appropriate doctor's order.

I give permission for the school nurse to communicate with teachers about the action and side effects of this/these medication(s).

I give permission for the school nurse to consult the above-named student's physician or pharmacist regarding any questions that arise regarding the listed medication or medical condition being treated with this medication.

Field Trips: I give permission for the assigned teacher or other responsible adult to dispense the medication on a field trip if necessary.

I agree to provide this medication in a container labelled by the pharmacy with the prescription date, prescription number, student's name, name of medication, dose, time to be given, prescriber's information.

By signing this form, parents/guardians provide authorization for their child's health care provider noted above via Medical records to send medical forms/information via fax, phone or mailed directly to the East Range Academy of Technology and Science School Nurse requesting information.

_____

Signature of Parent/Guardian *Relationship to Student* *Date*

East Range Academy of Technology and Scienc
2000 Siegel Boulevard, Eveleth, MN 55734 (218) 744-7965 FAX (218)744-2349

STUDENT HEALTH SURVEY Please Return to School Nurse ASAP

School Year	Grade	
Student Name	Sex	Birthdate

Parent/guardian name	Home phone	Work phone	Cell phone
Address			

Emergency Contact Person(s) with transportation who will care for children in case parents cannot be reached:	
1.Name	Phone
2.Name	Phone

Physician/Healthcare Provider	Phone

Does your child have any problems that may affect his/her learning or health in school, cause you any concern and/or are important for the school staff to know? The nurse may share health concerns that will affect a student at school, with the teacher or other school staff, unless otherwise requested in writing. Please check yes or no for each of the following items:

Concern	Yes	No	Please specify/explain
Health Concerns (ex: ADHD, Asthma, Vision, Hearing, Diabetes, Allergies, Headaches, Seizures, Etc.)			
Daily Medications at Home (Please List Medication name)			
Daily Medications at School (Name of medication, time to be administered, **Complete Medication Administration Form**)			
Health Precautions/Restrictions			
Has your child had any serious illnesses, surgery, accidents or hospitalizations this past year?			

Check if your child has any of the below noted health needs:		
___ Asthma w/inhaler	___ Asthma w/nebulizer	
___ Diabetes w/insulin	___ Diabetes w/insulin pump	___Emergency glucagon
___Seizure	__Seizure w/emergency diastat	___Other:
___Hearing deficit/concern	___ Vision deficit/concern	
___Bee/insect allergy	___Bee/insect allergy w/Benadryl	___Bee/insect allergy w/Epi-Pen
__Food allergy to:	___Food allergy w/Benadryl	___ Food allergy w/Epi-Pen
___ Allergy to Medication/other agents:		
___ Physical limitations:		
___ Medical condition that requires parents to be notified when (ie.) chicken pox, 5ths disease, measles, strep throat is diagnosed in other close-contact students.		

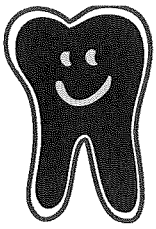
If your child received any immunizations this past year, please list below with the month, day, and year:

_____Tdap _____MMR _____ Hep B _____Polio _____Meningococcal _____Varicella _____Hep A

All medications needed for school must be provided by parents/guardians <u>and</u> the East Range Academy Of Technology and Science <u>**Medication Authorization Form completed requiring physician and parent signature**</u>. This form is available from the school. In the event of Emergency our procedure will be to contact the parents at home or at work. When this is not possible an ambulance will be called. Your Emergency Contact person may be asked to care for your child until you can be reached.

Signature of Parent/Guardian _____ Date _____

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE SCHOOL NURSE, Cindy Lustig, AT 744-7965



Children's Dental Services

Children's Dental Services (CDS) is a non-profit dental provider dedicated to providing care to children from birth to age twenty-six and pregnant women. CDS offers preventative, diagnostic, and restorative dental care to all school children within your child's school.

Upon completion of the attached consent, children are provided with dental care during school hours by Children's Dental Services.

CDS accepts all forms of public and private insurance. *No child is denied treatment due to an inability to pay.* We assist families in applying for medical assistance and offer a sliding scale discount program for families ineligible for medical assistance. Please contact us if you would like assistance in applying for medical assistance or the sliding scale program.

Visit our website at:

www.childrensdentalservices.org

If you have any questions regarding the consent form or care provided at your child's school, please contact

Sara Smith, Licensed Dental Hygienist and Manager, Children's Dental Services at:

612-746-4751 or ssmith@childrensdentalservices.org

EAST RANGE ACADEMY of technology & science

Children's Dental Services

Children's Dental Services (CDS) provides dental care at school, which may include exams, x-rays, cleanings, fluoride treatment, sealants, **silver diamine fluoride (SDF)**, fillings, crowns, extractions and other treatments as needed during regular school hours. If you would like your child to receive dental care or if you are able to fill out this form as an adult (18 years or older), please fill out this form and return it to school. ***Please note: Annual permission is required. CDS may need to call with questions prior to treatment; please be sure to provide a number to reach you during the school day.***

If you DO NOT want your child to be seen, please DO NOT fill out this form.

Step 1: Patient Information

Patient Name (print) _____ **Birth Date** _____ ☐ Male ☐ Female

Parents' Names (print) _____

Address _____ Zip Code: _____

Phone (____) _____ 2nd Phone (____) _____ Race/Ethnicity _____

Child's School _____ Grade _____ Teacher _____

Step 2: Dental Information

IS THE PATIENT HAVING ANY DENTAL-RELATED PAIN OR CONCERNS? ☐ **Yes** ☐ **No**

If yes, please explain: _____

HAS THE PATIENT SEEN THE DENTIST IN THE LAST 6 MONTHS? ☐ **Yes** ☐ **No**

IF YES: Approximate date of last dental visit: _____ Name of Clinic _____

Step 3: Insurance Information

CDS offers reduced cost to families who are income eligible.
If your child has no dental insurance, please call CDS at 612-746-1530 and ask about our sliding scale program.

A. Does the patient have insurance through the state? ☐**Yes** ☐**No** **If yes, what is the member ID number (PMI)** _____

B. Does the patient have private insurance through a parent's employer? ☐ **Yes** ☐ **No** **If yes, fill in information below:**

Name of Dental Insurance _____ Name of Employer _____

Policy Holder's Name/Name of Employee _____ Date of birth _____

Dental Plan Identification Number or Social Security # _____

Step 4: Medical History

1. **Indicate YES to all that applies to the patient, and indicate NO to all that DOES NOT apply to the patient.**

PLEASE MARK EVERY BOX.

ADHD/ADD	☐ Yes ☐ No	Cold sores or fever blisters	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Congenital heart disease	☐ Yes ☐ No	Hepatitis/liver disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Dental anxiety	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Artificial heart valve	☐ Yes ☐ No	Depression/psychiatric	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
Artificial joint	☐ Yes ☐ No	Developmental disability	☐ Yes ☐ No	Radiation/chemotherapy	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Autism spectrum	☐ Yes ☐ No	Drug addiction	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Epilepsy or seizures	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No
Chemical dependency	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No		

Please explain any boxes marked yes: _____

CONTINUE TO NEXT PAGE ——————→

PLEASE MARK EVERY BOX

2. Does the patient have any disease, condition, or problem not listed? ☐ Yes ☐ No
   If yes, please list _____
3. Does the patient have any allergies to food, drugs, SILVER, or medicines? ☐ Yes ☐ No
   If yes, to what and how do you/ your child react? _____
4. Is the patient taking any medicines, drugs, herbal supplements or vitamins? ☐ Yes ☐ No
   If yes, list all medications _____
5. Has the patient ever had any unusual reaction to a dental anesthetic? ☐ Yes ☐ No
6. Has the patient ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
7. Has the patient seen a physician within the past 2 years? ☐ Yes ☐ No
   If yes, for what reason? _____
8. Has the patient been hospitalized within the past 2 years? ☐ Yes ☐ No
   If yes, for what reason? _____
9. Has the patient ever had any operations or surgery? ☐ Yes ☐ No
   If yes, what was the reason? _____
   Were there any complications? (describe) _____
10. Is the patient pregnant now or possibly pregnant? ☐ Yes ☐ No ☐ N/A
    If yes, when is your due date? _____

Step 5: Review Authorization Information

Children's Dental Services Authorization for Dental Exam and Treatment: I give permission for CDS to provide a dental exam, preventive services, and required restorative care (dental treatment). Specifically I consent to routine dental treatments being performed on my child, including examinations, x-rays, cleanings, fluoride, and plastic sealants. **For the treatment of minor cavities, I consent to the use of silver diamine fluoride (SDF). I am aware that SDF will turn the decayed area of the tooth gray or black in color, I am also aware there is a risk that the use of SDF may not stop the decay, and that the tooth may still require a filling.** I understand that CDS staff may be in contact with me to obtain additional informed consent to provide restorative procedures such as fillings, crowns, extractions and other treatments if needed. I understand that with any procedure there are associated risks, but that these risks are often outweighed by the benefits of such treatment. **Risks of not having treatment done include the following:**

1. Tooth ache, tooth infection, or dental abscess that may cause pain, fever, swelling, and/or spread of infection to other parts of the body that can lead to potentially life-threatening complications.
2. Difficulty chewing and/or maintaining good nutrition.
3. Gum inflammation.
4. Development of cyst in gum tissue.
5. Facial swelling.
6. Tooth sensitivity to hot or cold.
7. Ongoing pain, bad breath, unpleasant taste in mouth and difficulty opening mouth.
8. Loss of teeth.

I also understand that while rare, there are certain inherent and potential risks in any treatment plan or procedure, and that such operative risks include but are not limited to the following:

1. Occasional bleeding of the gums that can last up to 12 hours.
2. Swelling of the face or pain or jaw stiffness that can last for several days.
3. Injury to adjacent teeth, tissue, or fillings.
4. Fracture of the jaw and necessity to surgically treat the fracture.
5. Injury to the nerve underlying the lower teeth, resulting in numbness, tingling, pain, or other sensory disturbances to the lip, cheek, chin, gums, teeth, and tongue.
6. Unexpected reaction to the anesthetic.
7. Infection in the tooth socket that can be painful, tender, and swollen if a permanent tooth is extracted.
8. Biting lip while still numb.

Step 6: **Sign and Date Consent Form**

I give permission for CDS to bill my insurance for any services provided to the individual listed for care and I understand that I am responsible for any amount not covered by the insurance. I give permission for CDS to share the patient's oral health information with the school and the school permission to share information necessary for the provision of care to the patient, to provide the most comprehensive care possible. I also give permission for the school to share student information with CDS (including class schedules and data). This consent form is valid for one year from the date signed unless revoked in writing to CDS. If I had any further questions about the risks and benefits of treatment or alternate treatment options I have contacted a provider at CDS to ask such questions and they have been answered adequately. I have had adequate time to make the decision to give consent freely. The medical history provided is accurate to the best of my knowledge. If my medical history changes I will inform CDS.

_____ _____

Parent/Guardian (or patients 18 years of age or older) Signature **Date**

**Please note: If you or your child is seen by one of CDS' hygienists this does not take the place of an exam; we recommend a full examination with the dentist within 6 months if he/she has not already done so.

EAST RANGE ACADEMY 2019-2020 CALENDAR

AUGUST '19

S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

- 13 Open House 3pm-6pm
- 21 Staff Day 8:30-3pm
- 22 Staff Day 8:30-3pm
- 26 11th &12th grade Orientation; STAR Test- 9:00am
- 27 9th & 10th grade Orientation; Parent Meeting- 9:00am
- 28 State Fair Field Trip

SEPTEMBER '19

S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

- 2 Labor Day
- 3 First Day of School
- 21 Renaissance Fair Field Trip

OCTOBER '19

S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

- 14 Columbus Day
- 17 NO SCHOOL-MEA
- 18 NO SCHOOL-MEA
- 26 Field Trip Day
- 31 Halloween

NOVEMBER '19

S	M	T	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

- 8 NO SCHOOL-Staff Day
- 11 Veterans Day
- 16 Field Trip Day
- 27-29 NO SCHOOL (Thanksgiving)

DECEMBER '19

S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

- 12 Bentleyville Field Trip (After School)
- 14 Crafts- 10am-3pm
- 23-31 NO SCHOOL (Christmas Vacation)

JANUARY '20

S	M	T	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

- 1-3 NO SCHOOL (Christmas Vacation)
- 20 MLK Day Field Trip Day
- 21 NO SCHOOL-Staff Day

FEBRUARY '20

S	M	T	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

- 17 NO SCHOOL-President's Day
- 22 Field Trip Day

MARCH '20

S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

- 14 Field Trip Day
- 19 NO SCHOOL-Staff Day
- 20 NO SCHOOL

APRIL '20

S	M	T	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

- 9-13 Spring Break-Easter
- 25 Field Trip Day

MAY '20

S	M	T	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

- 10 Mother's Day
- 20 Last Day of School
- 21 GRADUATION
- 22 NO SCHOOL-Staff Day
- 25 NO SCHOOL
- 26 Valley Fair Field Trip

JUNE '20

S	M	T	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

- 1 Summer School Starts Mon-Thurs (9am-Noon)
- 21 Father's Day
- 25 Last Day of Summer School

JULY '20

S	M	T	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

- 4 Independence Day