Fir Grove Elementary

Roseburg, Oregon

2023-2024

Fit for Learning, Fit for Life

1360 W. Harvard Ave

Roseburg, OR 97471

541-440-4085

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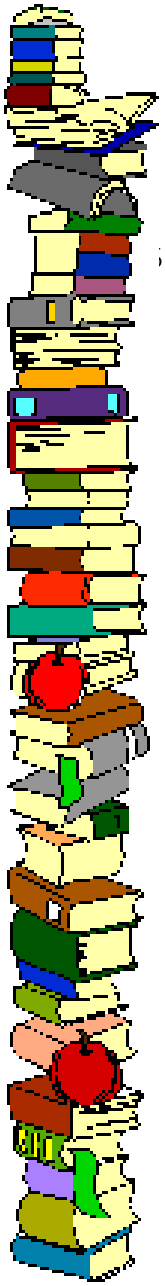
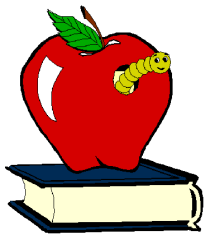


Fir Grove Elementary

Welcome to Fir Grove Elementary School!

We are pleased and excited that you and your child are part of our school. Fir Grove has a quality, caring, and dedicated staff who provide students with a positive, secure, and supportive environment where we place a major emphasis on reading, writing, mathematics, and respect. We believe that:

- All children can learn and succeed.
- A safe and respectful environment is everyone's right and responsibility.
- Families, schools, and the community are partners in every child's education.



Attendance:

We need your help to ensure that your child receives the best education possible. As you know, the single most important factor
in a child's education is the involvement of parents in school and parental support of the school. Please help us in the following ways:

- Make every effort to have your child in school and on time every day.
- Call when your child is too ill to attend.
- Please try to arrange for family vacations, doctor appointments etc. during non-school times.
- Contact the teacher and arrange to pick up missed assignments.

Support:

- Be involved in our school and the activities that are sponsored.
- Download the Remind app to receive updates from your child's teacher and to stay up to date with school news.
- Review papers, read the **newsletter** and notices that are sent home (via the Remind app) and visit our website; https://firgrove.roseburg.k12.or.us/
- Schedule a regular place and time for your child to complete homework.
- Avoid making negative or unsupportive comments about your child or our school in front of children.

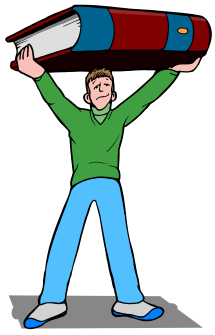
Discipline

We realize that you are primarily responsible for the discipline and behavior of your child and we encourage you to work with us on school-home plans to help your child be successful. We use Positive Behavior Interventions and Supports (PBIS) as well as Conscious Discipline. We offer incentives for individual students and for the whole school to motivate our students to follow our school rules. The following link will lead you to our adopted Board Policies that address student behavior.

District Administration

Jared Cordon	Superintendent	541-440-4014
Michelle Knee	Asst. Superintendent/Director of Teaching & Learning	541-440-4005
Robert Freeman	Director of Human Resources	541-440-4007
Melissa Roberts	Director of Student Services	541-440-4034
Cheryl Northam	Director of Business Services	541-440-4027

Board of Directors



Rebecca Larson	Charles Lee
Rev. Johnson	Anne Krimetz
Rod Cotton	
Dr. Brandon Bishop	
Andrew Shirtcliff	

FIR GROVE STAFF EXT. 2023-2024

1360 W. Harvard Blvd. Roseburg, OR 97471
Ph. 541.440.4085 Fax: 541.440.4086

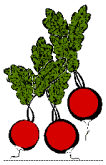
PRINCIPAL	Katrina Hanson	6302
KINDER	Amy Larman	6315
	Teri Moore	6312
FIRST	Jennifer Childers	6311
	Jenny Parnell	6310
SECOND	Michelle Hammond	6326
	Lindsay Ferguson	6327
THIRD	Jeff Jackson	6314
	Karami Miller	6313
FOURTH	Wesley Rea	6316
	Valerie Titus	6317
FIFTH	Courtney List	6318
	Dennis Park	6319
LRC	Sherryl Bailey	6322
DLC	Kristin Schriner	6308
CNC	Pam Schneider	6307
TITLE 1	Jenny Eames	6328
CDS	Corina VanBurger	6329
PE	Theresa Powell	6325
MUSIC	Taylor Siling	6323
TOSA	Jenny Carpenter	6325
PSYCHOLOGIST		6324
ELD	Karla Addington	6324

OFFICE MNGR	Lisa Jarrett	6300
OFFICE ASST.	Carole Whitehead	6301
LIBRARY	Tracy Clements	6320
CUSTODIANS	Jen McIntosh	
	Lowneza Brown	
KITCHEN	Dawn Cannon	6333
	Nadia Drygalov	6333
IA'S	TBD	LRC
	Sonja El-Badry	LRC
	Brook Laney	LRC
	Penny Faber	Title
	Brenda Burks	Title
	Colton Marsters	Title
	Kristina Smith	Kinder
	Kari Spencer	Kinder
IA'S – DLC		
	Rhonda Carter	
	Heather Clark	
	Brittany Davison	
	Alana Day	
	Wanda Harris	
	Judith Mitchell	
	Elliot Snyder	
	Susie Wentworth	
IA'S – CNC	Dana Olson	
	Katrina Austin	
	Sheila	
SKILLS TRAINER	Terri Wetzel	6325
SPEECH	Brandy Pickens	6334
	Ernest Barrett	

Updated June 2023

School Lunches

A nutritious balanced hot lunch with milk is served to students free daily.



Adult Lunches $4.05 (subject to change)

Our lunch program will allow students to make choices about what they get for lunch. Each month we will send home the *School Lunch Menu* and a *Monthly Calendar*. This way you and your child can plan ahead and make other choices if your child prefers not to eat what is being served.

Breakfast Program:

We are pleased to offer a free breakfast program for interested students. A balanced breakfast is served in our lunchroom between 8:30 - 9:10 a.m. every morning.

Elementary Schedule

Buses Arrive/Cafeteria Open	8:30 am
Classrooms open	8:40 am
Bell Rings	8:45 am
Lunch rotation runs between:	11:15 am – 1:00 pm
Student Dismissal	3:25 pm
Wednesday Schedule	2:25 pm

Arrival and Departure Procedures

The school grounds will open at **8:30** a.m. Students who walk to school **must not** arrive before 8:30 a.m. unless arrangements are made with the staff. There is no recess before school. Breakfast is served starting at 8:30, classrooms open to students at 8:40 and school starts at 8:45.

Dismissal Procedure

Dismissal is at 3:25 pm daily (**2:25 on Wednesdays**). Early pick-up is strongly discouraged. **EARLY** pick-up cuts into instructional time, is disruptive and prevents students from participating in the end-of-the-day traditions with their classmates and teacher. Parents are encouraged to schedule appointments after 3:30 p.m.

Bus riders board buses in the front of the building (parking lot area). Students will be dismissed from their classroom when their bus arrives.

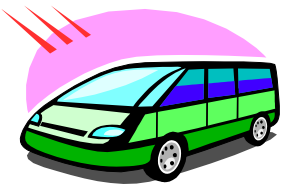
Walkers exit campus from one major access point: the southern gate on Harvard Ave.

Vehicle Pick-up is on **Stewart Park Drive** for ALL students.

- Cars will form a line, using the parking lot running the length of Stewart Park Drive (along the school).
- Staff will greet you and your child(ren) at the northern-most gate (close to the paved track) and will assist in walking your child(ren) to the gate. Please stay in your car and be alert to the flow of traffic.
- **If the side parking lot is full**, please use the Woolley Center/Art Center Parking lot and wait for the line to move up.
- **Please bring a dash of patience and grace.** It can get very busy; however, the more we work together, the smoother it will go!

- All students are to leave the school grounds after dismissal time.

- All skateboards, scooters and roller blades must be dismounted and carried while on the school campus. If damage is caused from intentional actions, confiscation may occur and will be returned to parents.
- **All students leaving the school grounds during school MUST have parent permission and MUST check out at the office and check-in upon returning.**
- Please make arrangements for early pick-up (or changes to transportation) by 2:30 every day (1:30 on Weds), please!



Student Activities

Although not school sponsored, the school works cooperatively with youth organizations such as the Boys and Girls Club, the YMCA, and Roseburg Soccer Association. Flyers are sent home or are made available in the office as received by these groups.

Parents and community members are encouraged to be involved as room volunteers, members of the Parent Teacher Organization, (Booster Club) field trip chaperones, and other activities throughout the year.

School Assemblies - Assemblies are scheduled throughout the year. Specific dates and times will appear in the monthly newsletter. Parents are welcome and encouraged to attend.

Special Programs

We have a variety of Specialists on our school staff to assist students and provide instruction to children who need special help.

- We have a **Learning Specialist** and **Instructional Assistants** for those who need assistance in reading or math.
- We have **Special Education** teachers and their team of **Instructional Assistants** to provide specialized support for students qualifying for an **Individualized Education Program (IEP).**
- Our **Child Development Specialist** is available to help children be more effective in dealing with life's pressures and stresses.
    - Parents may also work with the CDS in developing their skills, too. You will be contacted by the classroom teachers or the personnel mentioned above if your child might benefit from these services. Please feel free to contact the office or the school counselor for more information.
- The **Talented and Gifted (TAG)** Program represents a school philosophy of inclusion. The regular classroom teacher works with the family, our District TAG Coordinator, and our CDS to collaboratively determine a plan, if a child meets the rigorous qualifications (i.e., scoring at or above the 97th percentile on specific assessments). All 2nd and 4th grade students are screened for TAG qualifications.
- Our **English Language Development** program provides services for students with limited English proficiency. An **ELD** teacher may provide individual or small group instruction and consult with the classroom teacher to provide the best possible support.

Emergency School Closures

Each winter there is the possibility of extreme weather conditions that could cause school to delay opening, or classes to be cancelled. **In the event of bad weather**, three things could happen according to the administrative rules of the Roseburg School District:

1. Run school on a regular schedule.
2. Delay the start of school for two hours.
3. Close school for the entire day.

School Dress Code

The basic responsibility for attire to be worn at school or school related functions rests with the student and his or her parents. However, a student's dress and appearance may be regulated when, in the judgment of the school administrators, the student's dress or appearance:

- poses a health or safety hazard;
- promotes illegal or discriminatory conduct;
- is likely to cause a disruption of the educational process.

- Student attire that is too revealing cannot be worn at school. Undergarments must always be covered during school or at school-related activities.

- Dress or appearance should not lead school administrators to believe that a student's apparel, or accessories are gang related, promoting illegal or discriminatory activity, disrupting or interfering with the educational process.

A GOOD RULE:

- If you are unsure about the appropriateness of the clothing, please DO NOT wear it to school. Some clothing is appropriate for other places but NOT appropriate for SCHOOL!

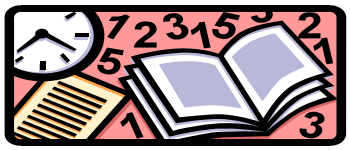
Lost and Found/Leaving toys at home

- Lost and Found items are displayed in the breezeway on the northern wall of the gym. Unclaimed items will be donated in September and January.
  - Please write your child's name in their coats, sweatshirts, sweaters, lunch bags, and backpacks with their first and last name.
- Toys, Games, and Trading Cards at School:
  - Personal items (such as these) should be left at home.
  - If they are brought to school for Show and Tell, they must remain in a backpack until it is time to show.
  - If they become a distraction, they could be taken away and returned directly to a parent.

Student Responsibilities

Students at Fir Grove are expected to:

1. Be familiar with the *District's Minimum Standards for Student Conduct & Discipline* and *Discipline in the Roseburg Public Schools*.
2. Be Safe, Respectful, and Responsible in classrooms, library, school buses, on school property and at school activities.
3. Maintain relationships with staff that are mutually respectful. Comply with staff directions and instructions promptly and courteously.
4. Use only language and gestures that are respectful and free of profanity and obscenity.
5. Follow all playground rules and use equipment in a safe manner.
6. Report fighting, inappropriate language, and intimidation to the nearest adult.
7. Report all accidents/injuries to your teacher or office.
8. Students are not allowed in classrooms during recess unless the teacher is present or has given specific permission for a student to be present.
9. Students on the bus are under the authority of the bus driver and are expected to follow rules governing conduct on the bus.
10. The telephone is for school business only. Students should make social arrangements at home. Students must have staff permission to use the telephone.
11. Skateboards, scooters and roller blades must be dismounted and carried while on the school campus.
12. Understand that all student misconduct will be corrected by any staff member when misconduct occurs within the school's jurisdiction.



Student Behavior

At Fir Grove we have established four Behavior Expectations to help students be successful at school. We continue to teach and reinforce these basic concepts throughout the year. Please review these expectations and help your child understand how important these are at school.

1. Be Safe
2. Be Respectful
3. Be Responsible
4. Always do your best

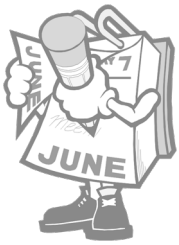
The Roseburg Public School District has policies that prohibit bullying, harassment and other offensive behavior. Any such behavior should be reported to the principal immediately. Violations of school rules and regulations, based upon the frequency and severity, may result in reprimand, warning, detention, removal of privileges, suspension and/or expulsion. In matters other than minor and routine, parents will be informed and involved. In all cases of suspension or expulsion, due process procedures will be in accordance with District Policy and Oregon Law. All students are expected to obey the laws of the State of Oregon and of the United States.

Library Media Center

The library media center is a vital asset to the school curriculum at Fir Grove. Students can check out materials for use in the classroom and at home. Materials that are lost or damaged will be charged to the student.

Communication

Monthly Newsletter – The Falcon Flyer is sent home through the Remind app to keep everyone informed about school and school activities. It will also be posted on our Facebook page.



Lunch Menu - Each month we will send home the *School Lunch Menu.* Please take time to review the menu with your child to decide which meals will be eaten. Great for posting on the refrigerator!

Absences – Please make every effort to have your child in school and on time each day. We ask that parents call the school whenever your child is absent. This is an important communication between the home and the school. Pre-arranged absences (trips, etc.) need to be handled through the office. Regular attendance influences performance significantly.

- You may leave a voicemail message for a teacher after hours. Simply call the school at 541-440-4085, then put in the teacher's extension. (See pg. 5 for extension #'s.)
- If you need to reach the office, press "0".

Questions and Concerns - Do you have a question or concern related to our school or your child? We are only a phone call away and know that questions or concerns left unaddressed

can become major problems. Please call us at 541-440-4085 make an appointment or to talk to any staff member.

Cell Phone/Electronic Device Policy

- Students are not encouraged to bring cell phones and electronic devices to school. Students who do so are assuming full liability for their device in the event of loss or breakage.
- Cell phones and electronic devices are not to interfere with the educational process.
- In an emergency, students may bring their phone to the office to call a parent or guardian then return the phone to their backpack.
- If a phone or device causes a disruption, that item will be confiscated. Students can retrieve their device in the office after school.
- Repeat offenses will mean that a parent or guardian will have to recover the device.
- Electronic readers will be used in an appropriate manner to enhance learning, not disrupt it.

Health Procedures and Accidents

- We do not have a school nurse and our facilities are extremely limited when caring for sick or injured students. You will be contacted to pick up your child when they are ill. If it appears that your child needs medical attention or has incurred a head injury, you will be promptly notified. **Should we be unable to locate you and the injury appears to be serious, we will take your child to the doctor or medical facility indicated on our records.**

- If you should need to send **prescription medication** to school with your child that you wish to have administered here, it must be in the **original container**. You will also need to fill out and sign a medication form describing the dosage, time of dosage, and giving permission to office personnel to give your child the medicine.

- **Children should be kept home when they are suffering from any infectious condition** such as a severe cold, high temperature, influenza, etc. In cases of scabies, impetigo, ringworm, head lice, or other highly contagious conditions, treatment by a physician or the Health Department may be required before a student may return to school (per policy JHC-AR).

- School administrators are required to deny admission to children who have not met immunization timetables. The law requires all students under age 14, attending an Oregon school to be immunized against the following: Diphtheria, Tetanus, Polio, Hepatitis, Measles, Mumps, Rubella, and Varicella.
- Please click on THIS LINK for our Suicide Prevention Policy at Roseburg Public Schools.

Fir Grove Booster Club

We are always looking for support from our families to assist with the Booster Club. This is an opportunity for families to connect, plan activities for students, and help keep the community connected. Please call our front office if you are interested in being a part of the Booster Club!

Parent - Teacher Conferences

Communication with parents about their student's educational progress is an important factor in the learning process. We encourage ongoing communication between school and home. Twice a year there is time set aside for Parent-Teacher conferences to meet and discuss your student's progress. Conference dates for the 2023-2024 school year are: November 1- 2 and April 11- 12.

Roseburg Public Schools

Please review the following pages, as some are required forms needing completed and signed, then turned into the school prior to your student attending.

Annual Notification of Rights – Our release of student information policy.

Elementary Transportation Form – Required for all K-5 students annually.

Google Apps for Education – Required for all NEW students to the district.

HKOP Consent for Dental Hygiene Services – Required for all K-5 students regardless if you are opting out or not.

Dental Screening Certification Form – Required for any K-5 student who has selected to "opt out" of the HKOP Dental Hygiene Services in order to collect more details that we are required to report to the state.

Medication Administration Form – Required for any student who needs medications administered during school hours.

Oregon Certificate of Immunization Status – Required for all NEW students to the district.

Permission Form – Required annually for all students. Secondary schools (grades 6-12) typically send home individual class permissions slips for upcoming activities or field trips.

Records Request Form – Required for all NEW students to the district.

Temporary Guardianship Agreement – Required for certain family circumstances. Please contact your child's school to find out if this applies to your family situation.

Meal Preference Request Form - This form is for non-medical meal preference requests. If a medical meal accommodation is required, a Medical Statement must be completed instead.

Nutrition Medical Statement to request special meals – Required in order to make meal modifications to accommodate children with disabilities.

American Indian 506 form – Required to be completed in order to provide services from the Title VI Indian Education Formula Grant Program.

Roseburg Public Schools

Office Use: Enrollment Date _____Record # _____ Date Requested _____Date Received_____

STUDENT RECORDS REQUEST

Please CIRCLE the enrolling school:

Eastwood Elementary 2550 SE Waldon St Roseburg OR 97470 Phone: 541-440-4180 **Fax: 541-440-4182**	**Fir Grove Elementary** 1360 W Harvard Ave Roseburg OR 97471 Phone: 541-440-4085 **Fax: 541-440-4086**	**Fullerton IV Elementary** 2560 W Bradford Roseburg OR 97471 Phone: 541-440-4081 **Fax: 541-440-4082**	**Green Elementary** 4498 SW Carnes Rd Roseburg OR 97471 Phone: 541-440-4127 **Fax: 541-440-4017**	**Hucrest Elementary** 1810 NW Kline St Roseburg OR 97471 Phone: 541-440-4188 **Fax: 541-440-4191**
Melrose Elementary 2960 Melrose Rd Roseburg OR Phone:541-440-4077 **Fax: 541-440-4078**	**Sunnyslope Elementary** 2230 SW Cannon Roseburg OR Phone: 541-440-4192 **Fax: 541-679-9485**	**Winchester Elementary** 217 Pioneer Way Roseburg OR 97495 Phone: 541-440-4183 **Fax: 541-440-4187**	**John C. Fremont Middle School** Attn: Registrar 850 W Keady Ct Roseburg OR 97471 Phone: 541-440-4055 **Fax: 541-440-4060**	**Joseph Lane Middle School** Attn: Registrar 2153 NE Vine St Roseburg OR 97470 Phone: 541-440-4104 **Fax: 541-440-4100**
Roseburg High School Attn: Sommer Popham, Registrar 400 West Harvard Roseburg OR 97470 Phone: 541-440-4139 **Fax: 541-440-4156** Email: spopham@roseburg.k12.or.us		**Roseburg Virtual School** Attn: Robin Crabtree 948 SE Roberts Roseburg OR 97470 Phone: 541-440-8278 **Fax: 541-440-4037** Email: rcrabtree@roseburg.k12.or.us		**Phoenix Charter School** Attn: Tisha Barber, Registrar 3131 NE Diamond Lake Blvd Roseburg OR 97470 Phone:541-440-1104 Fax:541-440-1124 Email: tbarber@roseburgphoenix.com

The following student has enrolled in Roseburg Public Schools. Please forward the following requested records (if available):

- ✓ Cumulative File
- ✓ Key to your grading and credit system
- ✓ Behavior file
- ✓ Smarter Balanced & State Test Scores (overall and breakdown/strand scores)
- ✓ Health/Immunization/Birth Certificate
- ✓ Official Transcript/Academic Progress Records TAG records
- ✓ Withdrawal Grades/Current schedule
- ✓ IEP, Special Education Records, and/or 504 Plan **(if special education records are kept at a different location, please forward this request to that location).**

Students Full Legal Name _____Grade_____ Preferred Name _____
Student Address/Phone _____
Gender _____ DOB _____ Place of Birth _____
Last School Attended _____
Address _____ Phone _____ Fax _____

*Parent/Guardian (or student over 18) Signature _____

***Print** Parent Name (or student over 18) _____ Date _____

Has your student been expelled from the previous school?_____Is your student on an IEP/504 (past or present)?_____

Do not write below this line.

Registrar _____ Date _____

Under ORS 326.575, both public and private schools must request student records from the youth's former school within ten days of when the student initially seeks enrollment. The former school has ten days after receipt of the request to transfer any education records.
Under ORS 339.260, a district may withhold records, diplomas, or grade reports until outstanding fees owed are paid, although not when an educational agency has requested the records for use in the appropriate placement of a student. Please Note: ORS 339-260, ORA581-21-340, and Federal Law 34CFR S 99 et.seq specifies that no parental signature is required for educational records to be released to another educational agency.

!! PLEASE COMPLETE AND RETURN TO THE SCHOOL YOU ARE REGISTERING WITH - REQUIRED FOR ANY STUDENT NEW TO THE DISTRICT !!

Roseburg Public Schools

ANNUAL NOTIFICATION OF RIGHTS:

The following is a notice to parents and eligible students (who are 18 years of age or older) of their rights regarding student records and information.

I. Annual Notification of Your Rights Under FERPA

As a parent/guardian of a Roseburg Public Schools (RPS) student you have certain rights regarding your child's education records under the Family Education Rights and Privacy Act (FERPA), and applicable state law. The rights are summarized below.

1. **Review of Student Records:** You have the right to inspect and review your child's education record. You may contact the principal of the student's school to request an appointment to review the records. The school will make arrangements for access and notify you of the time and place where your child's records may be inspected.
2. **Amendment of Student Records:** If you believe your child's records are inaccurate or misleading, you have a right to make a written request for the school to amend the records.
3. **Disclosure of Student Records:** Without your prior written consent, only individuals having a legitimate educational interest, officials in the school systems in which a student intends to enroll, and certain authorized officials may have access to your child's educational records. However, certain routine information, called *directory information*, may be disclosed without your consent. See Parental Privacy below.
4. **Right to File a Complaint:** If you believe your rights under FERPA have been violated you have the right to file a complaint with the Family Policy Compliance Office in the U.S. Department of Education.

All of the rights described above transfer to a student who is 18 years old or is attending a post-secondary education institution.

II. Student and Parent Information and Image Disclosure (Directory Information)

FERPA allows the District to provide *directory information* upon request without the prior permission of parents or students.

Directory Information includes the following items:

- Student's name, address and telephone listing
- Student's image (ex. photo, print, video)
- Student's grade level, teacher(s), class(es) and/or classroom(s)
- Student's gender
- Most recent previous school or program attended
- Parent(s) name and email address
- Date of birth
- Participation in sports and activities
- Weight and height of athletic team members
- Dates of attendance
- Degrees or awards received

The primary use of *directory information* is to allow for the inclusion of your child's information and image for school district use in publications such as yearbooks, class composites, playbills or other programs showing participation in athletics or activities, teacher and curriculum websites, and the District and school websites and social media.

Video and/or photographs of our students, their class activities, and their student work may be displayed in our buildings, on our websites, and used outside the District for District-authorized purposes.

We occasionally will release directory information upon request to third parties such as parent organizations and news media for directories or other means of supporting schools and school programs.

If you do NOT want the District to disclose directory information to include photo and video from your child's education records, you must notify the office at your child's school in writing within two (2) weeks of starting school. This notification must be submitted on an **annual** basis.

Classroom Internet Use - After being trained by school staff on the acceptable and appropriate use of technology, students will make use of the Internet on a regular basis for classroom instruction and online assessments. Student Internet use is monitored by staff and web content is filtered by Children's Internet Protection Act (CIPA) compliant tools. If you do not want your student to access the Internet at school **you must notify the office at your child's school in writing, prior to the start of school.** This notification must be submitted on an **annual** basis.

Additional forms may be required to complete your students registration, and can be located on our website by clicking on Registration Forms. From there you will be able to print, complete and sign any remaining forms. You will have the option to upload through ParentVue, or hand deliver to the school on their registration dates.

Everybody Brush! CONSENT FOR DENTAL HYGIENE SERVICES

Healthy Kids Outreach Program

Mercy Foundation and Advantage Dental want to help keep your community cavity-free and healthy. A Dental hygienists will be available on site during the year to provide free dental services. These services do not replace regular dental care from a dentist.

PATIENT INFORMATION

School Location:

Patient's Name: _____
Last Name First Name Middle Initial Date of Birth

My child has: ☐ OHP ☐ Private ☐ None Dentist: _____

Best phone number to reach you during the day: _____

Friend or family member's name and phone number to reach in case you change your number: _____

Address / City / State / ZIP: _____

Grade / Teacher:

Gender: ☐ M ☐ F ☐ Other ☐ Choose Not to Disclose

The following services may be offered to the patient on an as-needed basis. Please Initial on YES or NO to indicate whether you consent to these services being provided on the patient listed above.

Screening (Teeth Check-up)	YES	NO
Fluoride Coating	YES	NO
Sealant	YES	NO
Silver Fluoride	YES	NO
Antiseptic for the Teeth (Iodine)	YES	NO
Protective Restoration	YES	NO

List medications currently taking:

_____

_____

☐ Iodine Allergy

☐ Shellfish Allergy (shrimp, crab etc.)

☐ Other Allergies (please list): _____

_____

History of:

☐ Diabetes

☐ Asthma

☐ Tobacco Use

☐ Behavioral Considerations (please describe):

_____

Other (please describe): _____

_____

If you have questions or would like more information about the services provided, please call Mercy Foundation 541.677.4818 or see attached fact sheet.

Your signature indicates that you have been informed of the risks and benefits of treatment, your questions have been answered, and that you consent to the treatment indicated above.

As the parent/legal guardian, I agree to all of these statements:

- I give consent for dental services initialed/indicated above from Mercy Foundation, Advantage Dental Group, PC (Advantage Dental), and/or one of its representatives.
- The results of the oral hygiene services, including personal health information and scheduling information, may be shared between Advantage Dental, Mercy Foundation's Healthy Kids Outreach Program, the dental provider (hygienist or patient's dentist), the community site, any listed insurance carriers, the dentist of record, any applicable Coordinated Care Organization, and/or the Dental Care Organization of record for purpose of treatment, payment or healthcare operations.
- I have been given a copy of the "Notice of Privacy Practices" and HIE (Health Information Exchange) Notification.
- This consent will remain active for 12 months unless revoked in writing or by calling an Advantage Dental representative.
- This consent is valid at all sites where Mercy Foundation and Advantage Dental provides services.

If you have dental insurance through Medicaid, the Oregon Health Plan or Healthy Kids, the hygienist will notify the plan of the services received.

Print Parent/Legal Guardian Name: _____ **Relationship:** _____

Sign Here **Parent/Legal Guardian Signature:** _____ **Date:** _____

FACT SHEET

Not all patients may qualify for all services; provider will determine which services are clinically appropriate based on the patient's individual needs.

Screening (Teeth Checkup)

A dental care professional will look in the mouth to check for changes in teeth that may indicate cavities or other oral health problems.

Risk(s): Decay or other problems could exist and get worse if not discovered.

Alternative(s): No checkup.

Fluoride Coating

A temporary thin coating (also called varnish) put on the teeth to help protect from cavities. The coating is safe even if it is swallowed. It does not hurt or stain the teeth.

Risk(s): Allergy is not common.

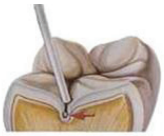
Alternative(s): Daily or weekly fluoride rinses, fluoride foam, or fluoride gels applied at your dentist's office.

Sealant

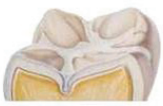
A dental sealant is a white coating put on the chewing surfaces of back teeth where cavities occur most often. Sealants make barriers on teeth that keep bacteria out and prevent cavities. They do not interfere with biting or chewing.

Risk(s): Sealants only protect the chewing surfaces. They can last for several years, but sometimes need to be replaced.

Alternative(s): Silver Fluoride. No sealants. Choosing not to use sealants could increase the chances you will develop decay in the chewing surfaces of the teeth.



Before Sealants



After Sealants

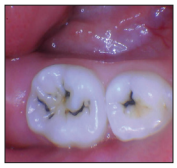
Silver Fluoride

Fluoride with silver looks like water. It is painted on the teeth with a tiny brush and can heal early tooth decay. It goes on quickly, and does not hurt. If there are cavities in the mouth, silver fluoride can stop them from growing, and sometimes even heal them. Cavities that are stopped or healed with Silver Fluoride will turn dark brown or black. Teeth without cavities will not change color. If the color shows a lot, a dental professional can cover it with white filling material. Fillings may not be needed for cavities that are stopped with Silver Fluoride.

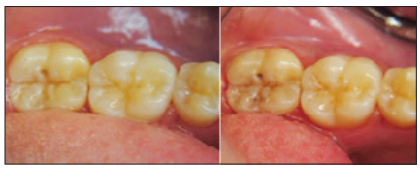
Risk(s): If Silver Fluoride comes in contact with skin it will cause a small dark spot that will go away on its own in 1-2 weeks. If it comes into contact with existing white fillings it might stain.

Alternative(s): No Silver Fluoride applied. This could leave harmful bacteria on your teeth and increase the chance of tooth decay. Use fluoride toothpaste regularly and have fluoride varnish and sealants applied at your dental office.

How Silver Fluoride looks on a tooth with a cavity



How Silver Fluoride looks on a tooth with no cavity



Before After

Antiseptic For The Teeth (Iodine)

The antiseptic kills bacteria that cause cavities. When applied before the fluoride coating, it prevents many more cavities than the fluoride coating alone. Iodine is a normal part of our diet from food and is safe. It does not hurt or stain the teeth.

Risk(s): Allergic reactions are not common, but you should not have this treatment if you are allergic to shellfish.

Alternative(s): No iodine applied. This could leave harmful bacteria on your teeth and increase the chance of tooth decay.

Protective Restoration

This is a simple tooth colored filling placed in a cavity to protect the tooth until a permanent filling can be done. It relieves pain and helps healing inside of the tooth. No shots are needed. It does not hurt.

Risk(s): Protective fillings may partially fall out, but what is left still protects the tooth.

Alternative(s): A regular filling or cap. Without care, the cavity may get bigger or become painful.

Advantage Dental
From DentaQuest

SUMMARY NOTICE OF PRIVACY POLICY

Our Responsibilities: We are required by law to make sure that your protected health information is kept private and follow the privacy practices that are described in our full Notice of Privacy Practices. We may change our privacy policies any time and notify you. You can also request copy of our full Notice of Privacy Practices at any time. For more information about our privacy policies, contact us at 1-866-268-9631.

Our Uses and Disclosures: We use your health information to treat you, manage the health care treatment you receive, run our organization and to pay or bill for your health services. For example, we can use your health information and share it with other providers who are treating you.

There are other ways we are allowed to share your information. These other reasons are so that we can help the public, like public health and research. We have to follow the law before we can share your information for these reasons. We will not use or share your information other than what the law allows us to do; unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.

Your Rights: When it comes to your health information, you have rights.

- You can ask to see or get a copy of your health information;
- You can ask us to correct your information;
- You can ask for confidential communications;
- You may ask us to limit what we use or share;
- You can get a list of those with whom we've shared information; and
- You can ask us for a copy of the full Notice of Privacy Practices at any time.

Your Choices: For certain health information, you can tell us your choices about what we share. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in payment for your care.
- Share information in a disaster relief situation.
- If you can't tell us what you want us to do, for example if you are not conscious, we may share your information if we think it is what is best for you. We may also share your information when needed to lessen a serious threat to health or safety.

Privacy Complaints: If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about your health information, you may contact us at 1-866-268-9631 or TTY 711. You also contact the US Department of Health and Human Services at 1-877-696-6775 or TTY 1-866-788-4089.

Summary of Privacy Practices: This is a summary of our Notice of Privacy Practices. You can ask us for the full Notice of Privacy Practices at any time.

To Improve the Oral Health of All
www.AdvantageDentalClinics.com
442 SW Umatilla Avenue Redmond, OR 97756 | TEL: 866.468.0022 | FAX: 866.268.9618

Advantage Dental
From DentaQuest

NON-DISCRIMINATION DISCLOSURE NOTICE

Advantage Dental and our providers comply with all applicable state and federal civil rights laws. We cannot treat people unfairly in any of our services or programs because of a person's:

- Age
- Color
- Disability
- Gender Identity
- Marital Status
- National Origin
- Race
- Religion
- Sex
- Sexual orientation

To report your concern or get more information please contact our Compliance Department one of these ways:

- Web: www.AdvantageDental.com
- Email: complianceline@advantagedental.com
- Phone: 1-866-654-3433, TTY 711
- By Mail: 442 SW Umatilla Ave., Redmond OR 97756

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can file a complaint electronically through the Office for Civil Rights Complaint Portal, available at https://ocrpor-tal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

If you would like to request this information in another language or an alternate format such as large print, audio disk, braille, etc. please contact Customer Service at 888-468-0022 or TTY 711.

LANGUAGE	TRANSLATED STATEMENT
English	ATTENTION: If you speak [language], you have services available to you free of charge for language assistance. Call 1-888-468-0022 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-468-0022 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-468-0022 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-468-0022 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-468-0022 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-468-0022 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-468-0022 (телетайп: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم- 711(رقم هاتف الصم والبكم: 1-888-468-0022).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-468-0022 (ATS : 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-468-0022 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-468-0022（TTY:711）まで、お電話にてご連絡ください。
Farsi	**وجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-468-0022 (TTY: 711) تماس بگیرید.
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-468-0022 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-468-0022 (መስማት ለተሳናቸው: 711).
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-1-888-468-0022 (TTY: 711).
Ukranian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-468-0022 (телетайп: 711).
Lao/Loatian	ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-468-0022 (TTY:
Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-468-0022 (TTY: 711).
Ibo	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-888-468-0022 (TTY: 711).
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-888-468-0022 (TTY: 711).

Everybody Brush! CONSENTIMIENTO PARA SERVICIOS DE HIGIENE DENTAL

Healthy Kids Outreach Program

Mercy Foundation y Advantage Dental quiere ayudar a mantener a su comunidad saludable y libre de caries. Higienistas dentales estarán disponibles en el local durante el año para proveer servicios dentales gratuitos. Estos servicios no reemplazan el cuidado dental regular de un dentista.

INFORMACIÓN DEL PACIENTE — Ubicación de escuela:

Nombre del paciente: _____
Apellido Nombre Inicial de Segundo Nombre Fecha de Nacimiento

Mi niño tiene: ☐ OHP ☐ Seguro privado ☐ Ningún seguro Dentista:

Mejor número de teléfono para comunicarnos con usted durante el día: _____
Nombre y numero de teléfono de un amigo o familiar para comunicarnos en caso de que cambie su número de teléfono:
_____

Dirección / Ciudad / Estado / Codigo Postal: _____

Grado:

Género: ☐ M ☐ F ☐ Otro ☐ Elijo No Divulgar

Los siguientes servicios podrían ser ofrecidos al paciente a base de necesidad. **Por favor ANOTE SUS INICIALES en SI o NO** para indicar si consiente a que estos servicios le sean proporcionados al paciente mencionado anteriormente.

Examen (Revision de Dientes)	SI	NO
Capa de Fluoruro	SI	NO
Selladores	SI	NO
Fluoruro de Plata	SI	NO
Antiséptico para los Dientes (Yodo)	SI	NO
Restauración Protectora	SI	NO

Lista de medicamentos que está tomando actualmente:
_____
_____

☐ Alergia al Yodo
☐ Alergia a los Mariscos (Camaron, cangrejo, etc.)
☐ Otras alergias (por favor enumere): _____
_____

Historial de:
☐ Diabetes
☐ Asma
☐ Uso de Tabaco
☐ Consideraciones de Comportamiento (por favor describa):
_____

Otro (por favor describa): _____
_____

Si tiene preguntas o le gustaría más información acerca de los servicios proporcionados, por favor llame al Mercy Foundation 541.677.4818 o vea la hoja informativa adjunta

Su firma indica que se le ha informado de los riesgos y beneficios de tratamiento, sus preguntas han sido respondidas, y que da su consentimiento para el tratamiento indicado arriba.

Como el padre/guardián legal, yo estoy de acuerdo con todas las siguientes declaraciones:

- Yo doy mi consentimiento para los servicios dentales con iniciales/indicados arriba de Mercy Foundation, Advantage Dental Group, PC ("Advantage Dental"), y/o uno de sus representantes.
- Los resultados de los servicios de higiene dental, incluyendo información de salud personal e información de citas, pueden ser compartidos entre Advantage Dental, Mercy Foundation's Healthy Kids Outreach Program, el proveedor dental (higienista o dentista del paciente), el sitio comunitario, cualquier aseguradora enumerada, el dentista de registro, y cualquier Organización de Atención Coordinada, y/o la Organización de Atención Dental de registro para propósitos de tratamiento, pago u operaciones de atención de salud.
- Se me ha dado una copia del "Aviso de Practicas de Privacidad" y Notificación de Intercambio de Información de Salud (HIE por sus siglas en ingles).
- Este consentimiento se mantendrá activo por 24 meses al menos que sea revocado por escrito o al llamar a un representante de Advantage Dental.
- Este consentimiento es válido en todo sitio donde Advantage Dental proporciona servicios.

Si usted tiene seguro dental por medio de Medicaid, el Plan de Salud de Oregon o Healthy Kids, el/la higienista notificará a su plan de los servicios recibidos.

Escriba en letra de molde del Padre/Guardián Legal: _____ **Relación:** _____

Firme Aqui **Firma del Padre/Guardián Legal:** _____ **Fecha:** _____

HOJA INFORMATIVA

No todos los pacientes podrían calificar para todos los servicios; el proveedor determinara cuales servicios son clínicamente apropiados basado en las necesidades individuales del paciente.

Evaluación (Chequeo de dientes)

Un profesional de cuidado dental mirara dentro de la boca para revisar si existen cambios en los dientes que podrían indicar caries u otros problemas de salud oral.

Riesgo(s): Carie u otros problemas podrían existir y empeorar si no son descubiertos.

Alternativa(s): No hacer el chequeo.

Capa de Fluoruro

Un capa delgada temporaria (también llamado barniz) aplicada a los dientes para ayudar a proteger contra caries. La capa es segura aun si es ingerida. Esta no perjudica ni mancha los dientes.

Riesgo(s): Una alergia no es común.

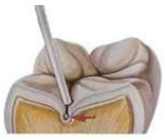
Alternativa(s): Enjuagues bucales de fluoruro diario o semanal, espuma de fluoruro, o gel de fluoruro aplicado en la oficina de su dentista.

Sellador

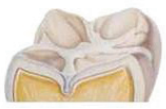
Un sellador dental es una capa blanca aplicada a las superficies de masticación de los dientes de atrás donde las caries suelen ocurrir más frecuentemente. Los selladores forman una barrera en los dientes que mantiene fuera a la bacteria y previene las caries. Estos no interfieren con el morder o el masticar.

Riesgo(s): Los selladores solo protegen las superficies de masticación. Pueden durar varios años, pero algunas veces necesitan ser reemplazados.

Alternativa(s): Fluoruro de Plata. No selladores. El elegir no utilizar selladores puede incrementar las posibilidades de desarrollar caries en las superficies de masticación de los dientes.



Antes de selladores



Despues de selladores

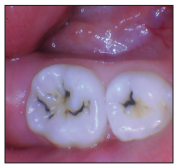
Fluoruro de Plata

El fluoruro con plata se ve como agua. Este es pintado en los dientes con un cepillo pequeño y puede sanar la carie dental precoz. Se aplica rápido, y no duele. Si existen caries en la boca, el fluoruro de plata puede prevenir el que crezca, y algunas veces hasta las sana. Las caries que son detenidas o sanadas con fluoruro de plata se tornaran café oscuro o negras. Los dientes sin caries no cambiaran de color. Si el color se enseña mucho, un profesional dental puede cubrirlo con material para un relleno blanco. Quizá no sean necesarios rellenos para las caries que so detenidas con fluoruro de plata.

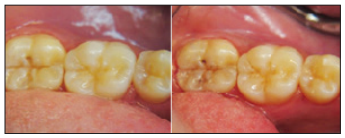
Riesgo(s): Si el fluoruro de plata se pone en contacto con la piel causara una pequeña mancha oscura que desaparecerá por sí misma en 1-2 semanas. Si se pone en contacto con rellenos blancos existentes quizá se manchen.

Alternativa(s): No aplicar fluoruro de plata. Esto podría dejar bacteria dañina en sus dientes e incrementar la posibilidad de caries dental. Utilizar una pasta dental con fluoruro regularmente y obtener aplicación de barniz de fluoruro y selladores en la oficina de su dentista.

Como se ve el Fluoruro de Plata en un diente con caries



Como se ve el Fluoruro de Plata en un diente sin caries



Antes Después

Antiséptico para los dientes (Yodo)

El antiséptico mata la bacteria que causa caries. Cuando es aplicada antes de una capa de fluoruro, previene muchas más caries que la capa de fluoruro por si sola. El yodo es una parte normal de nuestra dieta de comida y es seguro. Este no daña o mancha los dientes.

Riesgo(s): Reacciones alérgicas no son comunes, pero no debería de recibir este tratamiento si es alérgico a los mariscos.

Alternativa(s): No aplicar yodo. Esto podría dejar bacteria dañina en sus dientes e incrementar la posibilidad de caries dental.

Restauración Protectora

Este es un simple relleno del color del diente aplicado en la carie para proteger el diente hasta que se pueda aplicar un relleno permanente. Aliviar el dolor y ayuda a sanar dentro del diente. No se necesitan inyecciones. No duele.

Riesgo(s): Las restauraciones protectoras podrían parcialmente caerse, pero lo que permanezca seguirá protegiendo el diente.

Alternativa(s): Un relleno o capa regular. Sin cuidado, la carie podría crecer y hacerse dolorosa.

Advantage Dental
From DentaQuest

RESUMEN DE AVISO DE PRACTICAS DE PRIVACIDAD

Nuestras responsabilidades: Se nos requiere por ley el asegurar que su información de salud protegida se mantenga privada y seguir las prácticas de privacidad que son descritas en nuestro Aviso de Practicas de Privacidad completo. Podemos cambiar nuestras pólizas de privacidad en cualquier momento y dejarle saber a usted. Usted también puede solicitar una copia de nuestro Aviso de Practicas de Privacidad completo en cualquier momento. Para más información acerca de nuestras pólizas de privacidad, comuníquese con nosotros al 1-866-268-9631.

Nuestros usos y divulgaciones: Usamos su información de salud para tratarlo a usted, para administrar el tratamiento de cuidado de salud que usted recibe, para el manejo de nuestra organización y para pagar o facturar por sus servicios de salud. Por ejemplo, podemos usar su información de salud y compartirla con otros proveedores que la/lo estén tratando a usted.
Se nos permite compartir su información de otras maneras. Tales razones son para que podamos ayudar al público, tal como salud e investigación pública. Debemos seguir la ley antes de compartir su información por estas razones. No usaremos ni compartiremos su información mas allá de lo que nos permite la ley; al menos que usted nos diga por escrito que podemos. Si nos dice que si podemos, puede cambiar de opinión en cualquier momento.

Sus derechos: Cuando se trata de su información de salud, usted tiene derechos.
- Usted puede solicitar ver o recibir una copia de su información de salud;
- Usted puede solicitar que corrijamos su información;
- Usted puede solicitar comunicaciones confidenciales;
- Usted puede solicitar el que limitemos lo que usamos o compartimos;
- Usted puede recibir una lista de con quienes hemos compartido información; y
- Usted nos puede pedir una copia del Aviso de Prácticas de Privacidad complete en cualquier momento.

Sus Opciones: Para cierta información de salud, usted nos puede decir sus opciones acerca de lo que compartamos.
En estos casos, usted tiene el derecho y la opción de pedir que:
- Compartamos información con su familia, amigos cercanos u otros involucrados en el pago por su cuidado.
- Compartamos información en una situación de ayuda para catástrofes.
- Si usted no nos puede decir lo que quiere que hagamos, por ejemplo si no está consiente, podemos compartir su información si creemos que es lo mejor para usted. También podemos compartir su información cuando sea necesario para disminuir una amenaza seria a la salud o seguridad.

Quejas de privacidad: Si usted está preocupado(a) de que hemos violado sus derechos de privacidad, nuestras pólizas de privacidad, o si no está de acuerdo con una decisión que tomamos acerca de su información de salud, puede comunicarse con nosotros al 1-866-268-9631 o TTY 711. También puede comunicarse con el Departamento de Salud y Servicios Humanos de EE.UU. al 1-877-696-6775 o TTY 1-866-788-4089.

Resumen de prácticas de privacidad: Este es un resumen de nuestro Aviso de Prácticas de Privacidad. Usted puede solicitar el Aviso de Practicas de Privacidad completo en cualquier momento.

Advantage Dental
From DentaQuest

DIVULGACIÓN DE PÓLIZA ANTIDISCRIMINATORIA

Advantage Dental y su red de proveedores deben tratarlo/a justamente.

Nosotros y nuestros proveedores debemos seguir las leyes de derechos civiles estatales y federales. No podemos tratar a las personas injustamente en cualquiera de nuestros servicios o programas debido a su:

- Edad
- Color
- Discapacidad
- Identidad de Genero
- Estado Civil
- Origen Nacional
- Raza
- Religión
- Sexo
- Orientación sexual

Para reportar su preocupación o para recibir más información por favor comuníquese con nuestro Director de Derechos Civiles mediante una de las siguientes maneras:

- Web: www.AdvantageDental.com
- Correo electrónico: complianceline@advantagedental.com
- Teléfono: 1-866-654-3433, TTY 711
- Por Correo: 442 SW Umatilla Ave. Suite 200, Redmond OR 97756,

Usted también tiene el derecho de presentar una queja de derechos civiles con el Departamento de Salud de los EE.UU. y la Oficina de Servicios Humanos para los Derechos Civiles (OCR por sus siglas en ingles).

Comuníquese con esta oficina mediante una de las siguientes maneras:

- Web: www.hhs.gov/
- Correo electrónico: OCRComplaint@hhs.gov
- Teléfono: 1-800-368-1019, 800-537-7697 (TDD)
- Por Correo: OCR
  200 Independence Avenue SW
  Room 509F HHH Bldg
  Washington, DC 20201

Si le gustaría solicitar esta información en otro lenguaje o un formato alternativo tal como letra grande, disco audio, braille, etc. por favor comuníquese con Servicios al Miembro al 866-468-0022 o TTY 711.

LANGUAGE	TRANSLATED STATEMENT
English	ATTENTION: If you speak [language], you have services available to you free of charge for language assistance. Call 1-888-468-0022 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-468-0022 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-468-0022 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-468-0022 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-468-0022 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-468-0022 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-468-0022 (телетайп: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم- 711(رقم هاتف الصم والبكم: 1-888-468-0022).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-468-0022 (ATS : 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-468-0022 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-468-0022（TTY:711）まで、お電話にてご連絡ください。
Farsi	**وجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-468-0022 (TTY: 711) تماس بگیرید.
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-468-0022 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-468-0022 (መስማት ለተሳናቸው: 711).
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-1-888-468-0022 (TTY: 711).
Ukranian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-468-0022 (телетайп: 711).
Lao/Loatian	ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-468-0022 (TTY:
Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-468-0022 (TTY: 711).
Ibo	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-888-468-0022 (TTY: 711).
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-888-468-0022 (TTY: 711).

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child _____ Date of Birth _____ Grade level _____

Name of School _____ School District _____

Tribal Membership

The individual with Tribal membership is the (select only one): ◯ child ◯ child's parent ◯ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: _____

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

The Tribe or Band is (select only one):

- ◯ Federally Recognized Tribe
- ◯ State Recognized Tribe
- ◯ Terminated Tribe
- ◯ Alaska Native
- ◯ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ◯ Membership or enrollment number establishing membership (if readily available) or
- ◯ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). _____

Attestation Statement
I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Date _____

For Parent/Guardians:

Definitions:
Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

Student Information: Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

Tribal Membership: Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

Attestation Statement: Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

Paperwork Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335

AUTHORIZATION FOR MEDICATION ADMINISTRATION

DOUGLAS EDUCATION SERVICE DISTRICT

LISTEN • LEARN • LEAD

School: _____

Student's Name: _____ **DOB:** _____ **Grade:** _____

I am giving school personnel permission to administer medication(s) to my child per the following instructions:
Parent/Guardian must complete: (Please do not skip any questions)

Medication: _____ **Non-Prescription?:** Yes_____ No _____

Dose (strength/how much): _____ Prescription Number: _____

Frequency (how often): _____ Pharmacy Name: _____

Time of day for meds at school: _____ * Please allow my child to self-administer this medication.

Route (circle one): *Requires self-medication agreement form to be signed*

Mouth Ear Eye Nose Skin *by parent, school administrator, and if a prescription,*

consent of the physician. Yes: _____ No: _____

Start Date: _____ **End Date**: _____ **ALL MEDICATION MUST BE IN ITS**

Reason for medication: _____ **NEWEST ORIGINAL CONTAINER WITH**

Special Instructions: _____ **AN ACCURATE LABEL.**

****The written instructions from the physician for the administration of the prescription medication to the student must include the following:**

- Name of student, name of medication, route, frequency of administration, and other special instructions. This can be a prescription label if complete.

Important information for parents/guardians:

- I understand I am responsible to provide this medication and maintain the supply as needed.
- All medication must be provided from home and must be contained in its original-labeled container.
- Please include liquid measuring device. A teaspoon or tablespoon *cannot* be used for dispensing medication. If medication is to be cut in half, parents must do so before bringing to school. If medication is to be crushed, parents please provide a pill crusher.
- I understand that I am responsible to pick up all unused medication by the last day of school. I understand that any medication left at school will be discarded.

Parent/Guardian Signature: _____ Date: _____

(This authorization applies only to the medication listed above for the duration of treatment or school year.) My signature also authorizes an exchange of information as necessary between the school nurse, appropriate school personnel, and/or my child's health care provider.

1871 NE Stephens Street | Roseburg, OR 97470 | Office: 541-440-4777 | Fax: 541-440-4771
www.douglasesd.k12.or.us

OREGON DEPARTMENT OF EDUCATION

Dental Screening Certification Form

State law now requires a child who is 7 years of age or younger to have a dental screening before entering school for the first time. *HB 2972 (2015)*

IF YOUR CHILD HAS ALREADY RECEIVED A DENTAL SCREENING

Parent/Guardian:

- If you know your child has already had a dental screening, please check the box below, fill out this section, and sign it.
- If you do not know if your child has had a dental screening, please have a dental provider fill out this section and sign it.
- Please return this form to the school office.

☐ My child_____has received a dental screening.
(First name) (Middle initial) (Last name)

Parent/Guardian or Dental Provider

Print Name: ✍ _____

Signature ✍ _____ Date ✍_____

TO OPT-OUT OF THE DENTAL SCREENING REQUIREMENT

Parent/Guardian: You may choose to have your child opt-out of a dental screening due to a reason listed below. Please fill out this section and sign it. Then return this form to the school office.

My child_____was not screened due to the following:
(First name) (Middle initial) (Last name)

Please check all that apply:

☐ We already submitted a certification form at a previous school.
☐ The dental screening is contrary to student or families religious beliefs.
☐ The dental screening is a burden.

The dental screening is a burden for the student or the parent or guardian of the student when:

(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

Print Name ✍: _____

Signature ✍ _____ Date ✍_____

Roseburg Public Schools

Elementary Transportation Information

Students Name: _____Date: _____

School:_____Teacher Name: _____Grade: _____

Please note: *Please notify the school of any change of transportation plans* ***at least one hour*** *prior to the end of the school day. Wednesdays are early release days. All students must leave the school campus at the end of the day and go to their designated area. Any change of plans should be made* ***before*** *arriving to school with parent or guardian permission.*

My child will arrive at school by:

☐ Ride the bus - Bus#____ ☐ Walk ☐ Ride Bike ☐ Get dropped off

AM Bus Stop: _____

In the afternoon, my child will:

☐ Ride the bus home - Bus#____ ☐ Walk home ☐ Ride Bike home ☐ Get picked up

On Campus pickup location _____

☐ Ride the bus to Boys & Girls Club ☐ Ride bus to Daycare

☐ YMCA (Only available for Fullerton, Hucrest, and Melrose students)

PM Bus Stop:_____

Alternate Afterschool destinations:

Daycare Name: _____Address/Phone: _____

Name: _____Address/Phone: _____

Name: _____Address/Phone: _____

*If you require an alternating schedule, please indicate alternating **afternoon** transportation schedule:

	Bus	Pick-up	B&G Club	Daycare	Walk	Other
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						

Reminder: Wednesdays are early release days! *Only those listed on your registration forms will be allowed to pick up students, unless we have permission from a parent or guardian at least 1 hour prior to the end of the school day.*

Parent Signature: _____Date: _____

!! PLEASE COMPLETE AND RETURN TO THE SCHOOL YOU ARE REGISTERING WITH - REQUIRED FOR ALL ELEMENTARY STUDENTS !!

Roseburg Public Schools

Google Apps for Education

Student Permission Form

Roseburg Public Schools will provide students with Google Apps for Education accounts. Apps for Education includes free, web based programs providing word processing, spreadsheet, presentation and collaboration tools for Oregon students and teachers. This service is available through an agreement between Google and the State of Oregon.

Apps for Education runs on an Internet domain owned and managed by Roseburg Public Schools and is intended for educational use only. This permission form describes the responsibilities of the school, students and parents in using Apps for Education.

Apps for Education is available at school and at home via the web. School staff will monitor student use of Apps when students are at school. Parents are responsible for monitoring their child's use of Apps when accessing programs from home. Students are always responsible for their own behavior.

Student Use of Apps for Education

Apps for Education is primarily for educational use. Students may use Apps for personal use subject to the restrictions below and other school rules and policies which may apply.

- **Privacy** - School staff have access to student accounts for monitoring purposes. Students have no expectation of privacy on the Apps system.
- **Limited personal use** - Students may not use Apps tools for:
  - Unlawful activities
  - Commercial purposes or activities for personal financial gain
  - Inappropriate sexual or other offensive content
  - Threatening another person
  - Misrepresentation of Oregon Public Schools, staff or students.

Access Restriction

Access to and use of Apps for Education is considered a privilege accorded at the discretion of the District. The District maintains the right to immediately withdraw the access and use of Apps when there is reason to believe violations of law or District policies have occurred. In such cases, the alleged violation will be referred to the Principal for further investigation and possible action.

Student Name:_____ Graduation Year: _____

Parent/Guardian Permission

I give permission for my child to use Google Apps for Education. By doing so I agree to enforce acceptable use when my child is off School District Property.

Parent/Guardian signature:

_____ Date:_____

Roseburg Public Schools

Permissions Form

Field Trips

☐ **I Do /** ☐ **I Do Not Give** permission for my child to go and participate in off campus activities or field trips. These field trips are part of their learning program, and will primarily be within the community, although some may be to destinations that are more distant. Trips long enough to require transportation will be made in regular school buses or in some instances in parents' automobiles. You will be notified in advance regarding the time and destination of these field trips.

Consent to treatment of minor on field trip

☐ **I Do /** ☐ **I Do Not Give** permission for the school to obtain medical attention for my child in the event of a serious injury or accident. Your permission will authorize the school to call emergency services which may result in your child being taken to the hospital for emergency care. If circumstances allow, we will make every effort to contact you or your emergency person on file before contacting emergency services. Our first priority though, will be your child's immediate wellbeing. You will be financially responsible for medical treatment given to your child.

Movie Permission

☐ **I Do /** ☐ **I Do Not Give** permission to watch PG rated movies during class time. The movies are specifically chosen to coordinate with curriculum for each grade level. The teacher will have previewed the movies to ensure their appropriateness for a school showing.

_____ _____

Student Name Grade

_____ _____

Signature of Parent or Guardian Date

_____ _____

Printed Name of Parent or Guardian Relationship to student

!! PLEASE COMPLETE AND RETURN TO THE SCHOOL YOU ARE REGISTERING WITH - REQUIRED FOR ALL STUDENTS !!

Oregon Certificate of Immunization Status
Oregon Health Authority, Immunization Program

Oregon law requires proof of immunization be provided or an exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Health Authority, Immunization Program and may be released to the Authority or the local public health department by the school or children's facility upon request of the Authority. Please list immunizations in the order they were received.

Complete for all | Up-to-date | Medical | Non medical

Child's Last Name *Apellido*	First *Primer Nombre*	Middle Initial *Segundo Nombre*	Birthdate *Fecha de Nacimiento*
Mailing Address *Dirección*	City *Ciudad*	State *Estado*	Zip Code *Codigo Postal*
Parents' or Guardians' Names *Nombre de los padres o guardian*		Home Telephone Number *Número de Teléfono*	

Vaccines	**Dose 1**	**Dose 2**	**Dose 3**	**Dose 4**	**Dose 5**
Diphtheria/Tetanus/Pertussis (DTaP, Tdap, Td)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)
Booster Dose Tdap					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] ☐ Check here if child has had chickenpox disease _____ (mm/dd/yy)					
Measles/Mumps/Rubella (MMR)					
or					
Measles vaccine only					
Mumps vaccine only					
Rubella vaccine only					
Hepatitis B (Hep B)					
Hepatitis A (Hep A)					
Haemophilus Influenzae Type B (Hib) (Only children less than 5 years)					

I certify that the above information is an accurate record of this child's immunization history.

Signature* _____ Date

Update Signature _____ Date

Update Signature _____ Date

Update Signature _____ Date

*Parent, guardian, student at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

For school/facility use only
School/facility Name
Student ID Number
Grade

Continued On Reverse Side

Oregon Certificate of Immunization Status, Page 2
Oregon Health Authority, Immunization Program

Save

Child's Last Name *Apellido*	First *Primer Nombre*	Middle Initial *Segundo Nombre*	Birthdate *Fecha de Nacimiento*

Recommended Vaccines

Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Pneumococcal (PCV) (Only in children less than 5 years)					
Meningococcal (MCV4, MPSV4)					
Human Papilloma Virus (HPV) (9 years or older)					
Influenza (Flu)					
Other Vaccine Please specify:					
Other Vaccine Please specify:					

For medical exemptions:

Please submit a *letter* signed by a licensed physician stating:

- Child's name
- Birth date
- Medical condition that contraindicates vaccine
- List of vaccines contraindicated
- Approximate time until condition resolves, if applicable
- Physician's signature and date
- Physician's contact information, including phone number

For Immunity Documentation (history of disease or positive titer)**: Please submit a *letter* signed by a licensed physician stating:**

- Child's name and birth date
- Diagnosis or lab report
- Physician's signature and date

Nonmedical Exemption:

I have received information regarding the benefits and risks of immunizations. I understand that my child may be excluded from school or child care attendance if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):

- ☐ A health care practitioner
- ☐ The vaccine educational module approved by the Oregon Health Authority

I understand that I may decline one or more vaccinations for my child and request that my child be exempted from the following required immunizations (check all that apply):

- ☐ Diphtheria/ Tetanus/Pertussis
- ☐ Polio
- ☐ Varicella
- ☐ Measles/Mumps/Rubella
- ☐ Hepatitis B
- ☐ Hepatitis A
- ☐ Hib

Signature of Parent or Guardian _____ Date _____

Optional:

ORS 433.267 states that this document may include the reason for declining the immunization. Immunization is being declined because of:

☐ Religious belief ☐ Philosophical belief ☐ Other

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____

Temporary Guardianship Agreement

I, _____, of _____
(print your full name) (street)

_____, as the custodial parent of:
(city, state, zip)

List the full names of each child	List each child's birth date

Do hereby grant temporary guardianship of the above listed children to:

List the full names of the individual (s) to whom you are granting temporary custody	List person's relationship to the child(ren)

Contact information of temporary guardians listed above:

Address: _____

Phone numbers: _____ Cell _____ Work

_____ Home _____ Other

Statement of Consent: (To be signed in the presence of a legalized notary public.)

I, _____, *hereby grant temporary guardianship of the above children, whom I have*

legal custody of to _____

☐ From _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

☐ For as long as necessary, beginning on _____
(mm/dd/yyyy)

☐ Until the students turns 18 years old _____
Students date of birth

In addition, in the event of an emergency or non-emergency situation requiring medical treatment, I hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness. This permission includes, but is not limited to, the administration of first aid, and the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel. I also grant permission for the guardian(s) named above to make educational decisions for my child/children.

Signature: _____ Date: _____

Signature: _____ Date: _____

Notarization:

On this _____ day of _____, _____
(date) *(month)* *(year)*

_____
(name of parent)

personally appeared before me in _____, _____ and, in my presence,
(city) (state)

has/have satisfactorily identified him/her/themselves as the signer(s) of this Temporary Guardianship Form.

Name of Notary Official: _____

Signature: _____ Commission Expires: _____

Affix Notary

Seal Here

Roseburg Public Schools

Elementary Transportation Information

Students Name: _____Date: _____

School:_____Teacher Name: _____Grade: _____

Please note: *Please notify the school of any change of transportation plans* ***at least one hour*** *prior to the end of the school day. Wednesdays are early release days. All students must leave the school campus at the end of the day and go to their designated area. Any change of plans should be made* ***before*** *arriving to school with parent or guardian permission.*

My child will arrive at school by:

☐ Ride the bus - Bus#____ ☐ Walk ☐ Ride Bike ☐ Get dropped off

AM Bus Stop: _____

In the afternoon, my child will:

☐ Ride the bus home - Bus#____ ☐ Walk home ☐ Ride Bike home ☐ Get picked up

On Campus pickup location _____

☐ Ride the bus to Boys & Girls Club ☐ Ride bus to Daycare

☐ YMCA (Only available for Fullerton, Hucrest, and Melrose students)

PM Bus Stop:_____

Alternate Afterschool destinations:

Daycare Name: _____Address/Phone: _____

Name: _____Address/Phone: _____

Name: _____Address/Phone: _____

*If you require an alternating schedule, please indicate alternating **afternoon** transportation schedule:

	Bus	Pick-up	B&G Club	Daycare	Walk	Other
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						

Reminder: Wednesdays are early release days! *Only those listed on your registration forms will be allowed to pick up students, unless we have permission from a parent or guardian at least 1 hour prior to the end of the school day.*

Parent Signature: _____Date: _____

!! PLEASE COMPLETE AND RETURN TO THE SCHOOL YOU ARE REGISTERING WITH - REQUIRED FOR ALL ELEMENTARY STUDENTS !!

Oregon Department of Education
255 Capitol St. NE
Salem, OR 97310

Child Nutrition Programs
(503) 947-5894

Roseburg Public Schools

Meal Preference Request Form

Site/Provider Name:	**Submit this form to:** Your child's school

Part I To be completed by Parent/Guardian, Adult Participant, or Roseburg Public Schools

Name of Participant: _____

Parent/Guardian Name: _____ Phone #: _____

Part II To be completed by Parent/Guardian or Adult Participant
Note: This form is for non-medical meal preference requests. If a medical meal accommodation is required, a Medical Statement must be completed instead.

1. Check one or more boxes: Additional instructions are available on the back of this form

☐ A. The participant requests a Nutritionally Equivalent Milk Substitute[5]

Nutritionally Equivalent Milk Substitute Available: _____
(List full brand name/flavor)

☐ B. The participant requests other non-medical[5] food accommodations, fill out section below

Food(s) to be Omitted:	Suggested Substitution(s):
_____	_____
_____	_____
_____	_____

2. Signature and Date of Parent/Guardian or Adult Participant:

_____ _____ _____
Printed Name Signature Date

Part III Roseburg Public Schools Use Only

Oregon Department of Education
255 Capitol St. NE
Salem, OR 97310

Child Nutrition Programs
(503) 947-5894

Accommodation(s) Made: _____

Sponsor Signature: _____ Date: _____

Oregon Department of Education
255 Capitol St. NE
Salem, OR 97310

Child Nutrition Programs
(503) 947-5894

Instructions for completing the Meal Preference Request Form:

1. **Organization Name:** Include the name of the Sponsoring Organization that is providing the form
2. **Site/Provider Name:** Print the name of the site where meals will be served (e.g., ABC School, XYZ Child Care Center)
3. **Submit this form to:** Include the name and contact information for the organization staff who will be collecting the completed form
4. **Part I:** This section can be completed by the **Parent/Guardian, Adult Participant, or Organization**
    a. **Name of Participant:** Print the first and last name of the child or adult participant
    b. **Parent/Guardian Name:** Print the first and last name(s) of the parent or guardian. This is not required for adult participants.
    c. **Phone #:** Include a number for the parent/guardian in case of questions
5. **Part II:** This section must be completed by the **Parent/Guardian or Adult Participant** except for the Nutritionally Equivalent Milk Substitute Available section.
    a. In section 1 – **check one or more boxes**: Check all boxes that apply.
        i. A **Nutritionally Equivalent Milk Substitute** is defined as a non-dairy substitute that is nutritionally equivalent to cow's milk, as outlined in the National School Lunch Program (NSLP) regulations at 7 CFR 210.10(d)(3). Not all non-dairy substitutes will meet this requirement. For more information and a list of acceptable substitutes, refer to the ODE CNP Meal Accommodations and Modifications page.
        ii. **Nutritionally Equivalent Milk Substitute Available:** The Sponsoring Organization will include the full name and flavor of the Nutritionally Equivalent Milk Substitute that is available per the Organization's policy. If available, it must be provided at no extra charge for participants.
        iii. **A non-medical food accommodation** may include any meal accommodations due to religious, cultural, or personal preference (e.g., vegetarian, Kosher, etc.)
        iv. If the non-medical food accommodation is checked, include both the **food(s) to be omitted and the suggested substitution(s)**. Sponsoring Organizations may omit all food(s) as requested and may also accommodate suggested substitutions according to their organization's policies.
    b. In section 2 – **Signature and Date of Parent/Guardian or Adult Participant:** Print the full name of the parent/guardian or adult participant who is requesting the accommodation, sign, and date. This form will be considered incomplete if this section is not filled in.
6. **Part III**: This section must be completed by the Sponsoring Organization after Parts I and II are completed.
    a. **Accommodations Made**: The Sponsoring Organization staff will indicate what accommodations will be made for the requests made in Part II. All non-medical food substitutions served must meet meal pattern in order to be reimbursable.
    b. **Sponsor Signature and Date**: The Sponsoring Organization staff will sign and date the form. This form will be considered incomplete if this section is not filled in.

This form is only for non-medical meal preference requests and accommodations are subject to policies set by the Sponsoring Organization. Participants requiring a medical meal accommodation should be provided with a Medical Statement to be filled out by a licensed medical professional.

Oregon Department of Education
255 Capitol St. NE
Salem, OR 97310

Child Nutrition Programs
(503) 947-5894

Roseburg Public Schools

Medical Statement to Request Special Meals and/or Accommodations

Federal law and USDA regulation require Child Nutrition Programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal dietary preferences.

Site/Provider Name:	**Submit this form to:**

Part I To be completed by Parent/Guardian, Adult Participant, or Roseburg Public Schools

Name of Participant: _____

Parent/Guardian Name: _____ Phone #: _____

Part II To be completed *only* by a State licensed health care professional who is authorized to write medical prescriptions under State law*. Complete questions 1-3.

1. **Describe** the major life activity or major bodily function(s) affected by the participant's physical or mental impairment that restricts the diet:
   _____
   _____
2. **Meal Accommodation Plan (Foods to omit or avoid):**
   _____
   _____
3. **Foods to be substituted and recommended alternatives (include modification and accommodation):**
   _____
   _____

Signature of State Licensed Health Care Professional:

_____	_____	_____
Printed Name	Signature	Date

Part III Roseburg Public Schools Use Only

Accommodation(s) Made: _____

_____

Sponsor Signature: _____ Date: _____

Oregon Department of Education
255 Capitol St. NE
Salem, OR 97310

Child Nutrition Programs
(503) 947-5894

Instructions for completing the Meal Preference Request Form:

1. **Organization Name:** Include the name of the Sponsoring Organization that is providing the form
2. **Site/Provider Name:** Print the name of the site where meals will be served (e.g., ABC School, XYZ Child Care Center)
3. **Submit this form to:** Include the name and contact information for the organization staff who will be collecting the completed form
4. **Part I:** This section can be completed by the **Parent/Guardian, Adult Participant, or Organization**
    a. **Name of Participant:** Print the first and last name of the child or adult participant
    b. **Parent/Guardian Name:** Print the first and last name(s) of the parent or guardian. This is not required for adult participants.
    c. **Phone #:** Include a number for the parent/guardian in case of questions
5. **Part II:** This section must be completed by a **State licensed health care professional*:**
    a. In section 1 – **Describe:** The major life activity or major bodily function affected by the participant's physical or mental impairment that restricts the diet.
    b. In section 2 – **Meal Accomodation Plan:** Provide any foods to omit or avoid.
    c. In section 3 – **Foods to be substituted and recommended alternatives:** Provide the modification and accommodation.
6. **Part III**: This section must be completed by the Sponsoring Organization after Parts I and II are completed.
    a. **Accommodations Made**: The Sponsoring Organization staff will indicate what accommodations will be made for the requests made in Part II.
    b. **Sponsor Signature and Date**: The Sponsoring Organization staff will sign and date the form. This form will be considered incomplete if this section is not filled in.

This form is only for participants requiring a medical meal accommodation and should be filled out by a licensed medical professional*. Participants requesting a Non-Medical Meal Accommodation and/or a Milk Substitution will use the Meal Preference Request Form.

***State License Health Care Professions** include: Medical Doctors of Medicine (MD); Doctors of Osteopathy (DO); Doctors of Naturopathy (ND); Physician's Assistant (PA); Certified nurse practitioner or clinical nurse specialist; Doctor of Dental Medicine (DMD); Doctor of Dental Surgery (DDS); Doctor of Optometry (OD).

Departamento de Educación de Oregon
255 Capitol St. NE
Salem, OR 97310

Programas de nutrición infantil
(503) 947-5894

Roseburg Public Schools

Declaración médica para solicitar comidas y/o adaptaciones especiales

La ley federal y la norma del USDA exigen que los programas de nutrición infantil realicen modificaciones razonables para adaptarse a los niños con discapacidad. Según la ley, una discapacidad es un impedimento que limita sustancialmente una actividad vital importante o una función corporal, lo que puede incluir alergias y afecciones digestivas, pero no incluye las preferencias dietéticas personales.

Envíe este formulario a:	**Nombre del sitio o proveedor:** La escuela de su hijo

Parte I A rellenar por el padre/tutor o patrocinador o Roseburg Public Schools

Nombre del participante: _____

Nombre del padre / tutor: _____ Teléfono #: _____

Parte II Para ser completado sólo por un profesional de la salud con licencia estatal que esté autorizado a escribir recetas médicas bajo la ley estatal*. Conteste las preguntas 1-3.

1. **Describa la actividad principal de vida o la función corporal importante afectada por la discapacidad física o mental del participante que restringe la dieta:**
   _____
   _____
2. **Plan de Adaptaciones de Comida (Alimentos a omitir o evitar):**
   _____
   _____
3. **Alimentos a sustituir y alternativas recomendadas (incluir modificación y adaptación):**
   _____
   _____

Firma del Profesional de atención médica licenciado*:

_____ _____ _____
Nombre Firma Fecha

Part III Roseburg Public Schools uso exclusivo

Adaptación realizada: _____

_____

Firma del patrocinador: _____ Fecha: _____

Departamento de Educación de Oregon
255 Capitol St. NE
Salem, OR 97310

Programas de nutrición infantil
(503) 947-5894

Instrucciones para rellenar el formulario de declaración médica para solicitar comidas especiales y/o adaptaciones:

1. **Nombre de la organización:** Incluya el nombre de la organización patrocinadora que proporciona el formulario
2. **Envíe este formulario a:** Incluya el nombre y la información de contacto del personal de la organización que recogerá el formulario cumplimentado
3. **Nombre del sitio/proveedor:** Escriba el nombre del lugar donde se servirán las comidas (por ejemplo, Escuela ABC, Guardería XYZ)
4. **Parte I:** Esta sección puede ser completada por el **padre/tutor, participante adulto u organización**
   a. **Nombre del participante:** Escriba el nombre y el apellido del niño o del adulto participante
   b. **Nombre del padre/tutor:** Escriba el nombre y los apellidos del padre o tutor. Esto no es necesario para los participantes adultos.
   c. **Núm. de teléfono:** Incluya un número de teléfono para los padres/tutores en caso de preguntas
5. **Parte II:**Esta sección debe ser completada por un **profesional de la salud autorizado por el Estado:**
   a. En la sección 1 - **Describa:** La principal actividad vital o la principal función corporal afectada por la discapacidad física o mental del participante que restringe la dieta
   b. En la sección 2 - **Plan de adaptación de comidas:** Indique los alimentos que debe omitir o evitar
   c. En la sección 3 - **Alimentos a sustituir y alternativas recomendadas:** Proporcionar la modificación y adaptación.
6. **Parte III:** Esta sección debe ser completada por la Organización Patrocinadora después de completar las Partes I y II.
   a. **Adaptaciones realizadas**: El personal de la Organización patrocinadora indicará qué adaptaciones se harán para las solicitudes presentadas en la Parte II.
   b. **Firma del patrocinador y fecha**: El personal de la organización patrocinadora firmará y fechará el formulario. Este formulario se considerará incompleto si no se rellena esta sección.

Este formulario es sólo para los participantes que necesiten una adaptación médica para la comida y debe ser rellenado por un profesional médico autorizado. Los participantes que soliciten una adaptación de comida no médica y/o una sustitución de leche utilizarán el formulario de solicitud de preferencia de comida.

*** Profesional de la salud autorizado por el Estado**: Doctores en Medicina (MD); Médicos de Osteopatía (DO); Médicos de Naturopatía (ND); Asistente de médico (PA); Enfermera profesional certificada o enfermera clínica especializada; Doctor en Medicina Dental (DMD); Doctor en Cirugía Dental (DDS); Doctor en Optometría (OD)

OREGON DEPARTMENT OF EDUCATION

Formulario de certificación de examen dental

La ley estatal ahora exige que a los niños menores de 7 años se les haga un examen dentalantes de ingresar a la escuela por primera vez. *HB 2972 (2015)*

SI A SU HIJO YA LE HICIERON UN EXAMEN DENTAL

Padre de familia/tutor:

- Si sabe que a su hijo ya le hicieron un examen dental, marque la casilla de abajo, lleneesta sección, y fírmela.
- Si no sabe si a su hijo le hicieron un examen dental, pídale a un proveedor dental que llene esta sección y la firme.
- Devuelva este formulario a la oficina de la escuela.

☐ A mi hijo, _____, le han hecho un examen dental.
(Nombre) (Inicial del segundo nombre) (Apellido)

Padre de familia/tutor o proveedor dental

Nombre en letra de molde: _____

Firma: _____Fecha: _____

PARA EXCLUIRSE DEL REQUISITO DE EXAMEN DENTAL

Padre de familia/tutor: usted puede optar por excluir a su hijo de un examen dental por uno de los motivos que se indican abajo. Llene esta sección y fírmela. Luego, devuelva este formulario a la oficina de la escuela.

A mi hijo, _____, no le hicieron un examen dental debido a lo siguiente:
(Nombre) (Inicial del segundo nombre) (Apellido)

Marque todas las opciones que correspondan:

☐ Ya presentamos un formulario de certificación en una escuela anterior.

☐ El examen dental va en contra de las creencias religiosas del estudiante o de la familia.

☐ El examen dental es una carga.

El examen dental es una carga para el estudiante o el padre de familia o tutor del estudiante cuando:

(A) El costo del examen dental es demasiado elevado;

(B) El estudiante no tiene acceso a una persona que le haga el examen dental; o

(C) El estudiante no pudo conseguir una cita con una persona que le hiciera el examen dental

Padre de familia/tutor

Nombre en letra de molde:_____

Firma: _____ Fecha: _____

Para uso de la oficina: Fecha de inscripción_____N.º de distrito_____Grado_____

SOLICITUD DE FICHAS ESCOLARES

Haga un círculo alrededor de la escuela de inscripción:

Escuela Primaria Eastwood 2550 SE Waldon St Roseburg: OR.97470 Teléfono: 541-440-4180 Fax:541-441-4185	**Escuela Primaria Fir Grove** 1360 W Harvard Ave Roseburg OR 97471 Teléfono: 541-440-4085 Fax: 541-440-4086	**Escuela Primaria Fullerton IV** 2560 W Bradford Dr Roseburg OR 97471 Teléfono: 541-440-4081 Fax: 541-440-4082	**Escuela Primaria Green** 4498 SW Carnes Rd Roseburg OR 97471
Escuela Primaria Hillcrest 1610 NW Kline St Roseburg OR 97471 Teléfono: 541-440-4188 Fax: 541-440-4191	**Escuela Primaria Melrose** 2960 Melrose Rd Roseburg OR Teléfono: 541-440-4077 Fax: 541-440-4078	**Escuela Primaria Sunnyslope** 2230 SW Cannon Rd Roseburg OR Teléfono: 541-440-4192 Fax: 541-440-9485	**Distrito Escolar de Enseñanza Pública Roseburg** Escuela Primaria Winchester 217 Pioneer Way Winchester OR 97495

Escuela Intermedia John C. Fremont Atención: encargada de admisión 850 W Keady Ct Roseburg OR 97471 Teléfono: 541-440-5400 Fax: 541-440-4600	**Escuela Primaria Hillcrest** Atención: encargada de admisión 2153 NE Vine St. Roseburg OR 97470 Teléfono: 541-440-5300 Fax: 541-440-4100	**Escuela Primaria Hillcrest** Atención: encargada de admisión 400 West Harvard Roseburg OR 97470 Teléfono: 541-440-4199 Fax: 541-440-4156

El siguiente estudiante está inscrito en el Distrito Escolar de Enseñanza Pública Roseburg. Envíe las siguientes fichas escolares (si están disponibles):

- o Expediente académico
- o Expediente de conducta
- o Certificado de salud/vacunas/nacimiento
- o Expediente académico oficial/registros de progreso académico
- o Grado en que se retiró/horario actual
- o Programa de Educación Individualizado (IEP), registros de Educación Especial, y/o Plan 504 **(Si se guardan registros educativos en otro lugar, envíe esta solicitud a ese lugar),**
- o Clave de su sistema de calificación y créditos
- o Calificaciones de las Evaluaciones Equilibradas y Más Inteligentes y de las pruebas estatales (calificaciones generales y desglosadas/estándar).
- o Registros del Programa para Estudiantes Dotados y Talentosos (TAG)

Nombre legal completo del estudiante: _____

Nombre preferido: _____

Dirección/teléfono del estudiante _____

Sexo_____Fecha de nacimiento_____Lugar de nacimiento _____

Última escuela a la que asistió_____Dirección_____

Ciudad_____Estado/código postal____ Teléfono_____Fax____

*Firma del padre de familia/tutor (o estudiante mayor de 18 años)_____

*Nombre del padre de familia en letra de molde (o estudiante mayor de 18 años) _____Fecha____

No escriba debajo de esta línea.

Encargada de admisión_____Fecha_____

Conforme a ORS 326.575, tanto las escuelas públicas como las escuelas privadas deben solicitar las fichas escolares a la escuela del joven en un lapso de diez días de la fecha en que el estudiante pretende inscribirse. La escuela anterior tiene diez días después de la recepción de la solicitud para transferir toda ficha escolar.
Conforme a ORS 339.26 01, un distrito puede retener las fichas, diplomas, o informes de calificaciones hasta que se paguen las cuotas pendientes de pago, aunque no puede hacerlo cuando una agencia educacional haya solicitado las fichas para usarlas en la asignación pertinente de un estudiante. Nota: ORS 339-260, ORS 1-12-340, y la ley federal 34CFR 899 y siguientes especifican que no se necesita la firma de un padre de familia para que las fichas escolares se transfieran a otra agencia educacional.

Distrito Escolar de Enseñanza Pública **Roseburg**

Información sobre el transporte de la escuela primaria

Nombre del estudiante:_____Fecha:_____

Escuela: Escuela Primaria Winchester Nombre del maestro:____Grado:_____

Nota: *notifique a la escuela de todo cambio en los planes en materia de transporte* ***por lo menos una hora*** *antes de que termine el día escolar. Los miércoles son días de salida temprana. Todos los estudiantes deben salir del campus escolar al final del día e ir al área que les designaron. Todo cambio de planes debe hacerse* ***antes*** *de llegar a la escuela con el permiso del padre de familia o tutor.*

Mi hijo llegará a la escuela:

☐ En el autobús - N.º de autobús__☐ Caminando ☐ ☐ Lo dejarán en la mañana
En bicicletaParada del autobús:_____

Por la tarde, mi hijo:

☐ Se irá a casa en autobús - N.º de autobús_____ ☐ Se irá a casa caminando
☐ Se irá a casa en bicicleta ☐Vendrán a buscarlo

☐ Se irá en autobús al Club de Niños y Niñas ☐ Se irá en autobús a la guardería

☐ Asociación Cristiana de Jóvenes (YMCA) (Disponible únicamente para los estudiantes de Fullerton, Hillcrest, y Melrose) **Por la tarde**
Parada del autobús:_____

Destinos alternativos después de clases:

Nombre de la guardería:_____Dirección/teléfono:_____
Nombre:_____Dirección/teléfono:_____

Si necesita un horario alternativo, indique el horario de transporte alternativo **por la tarde**:

	Autobús	Vienen a buscarlo	Club de Niñosy Niñas	Guardería	Va caminando	Otro
Lunes						
Martes						
Miércoles						
Jueves						
Viernes						

Recordatorio: ¡Los miércoles son días de salida temprana! *Solo las personas que aparecen en sus formularios de inscripción tendrán permitido venir a buscar a los estudiantes, a menos que tengamos el permiso de un padre de familia o tutor por lo menos 1 hora antes de que termine el día escolar.*

Firma del padre de familia:_____Fecha:_____

Distrito Escolar de Enseñanza Pública **Roseburg**

Formulario de permiso

Excursiones escolares

☐ Doy / ☐ **No doy** permiso a mi hijo para ir a participar en actividades fuera del campus ni excursiones escolares. Estas excursiones escolares son parte de su programa de aprendizaje, y se harán principalmente dentro de la comunidad, aunque algunas pueden hacerse a destinos más lejanos. Las excursiones suficientemente largas para las cuales se necesite transporte se harán en los autobuses escolares regulares o, en algunos casos, en los automóviles de los padres de familia. Se le notificará con antelación con respecto a la hora y el destino de estas excursionesescolares.

Consentimiento para administrar un tratamiento a un menor en una excursión escolar

☐ Doy / ☐ **No doy** permiso para que la escuela reciba atención médica para mi hijoen el caso de una lesión o accidente grave. Su permiso autorizará a la escuela a llamar a los servicios de emergencia, los cuales pueden llevar a su hijo al hospital para que reciba atención urgente. Si las circunstancias lo permiten, haremos todo lo posible por comunicarnos con usted o con el contacto de emergencia que aparece en sus archivos antes de comunicarnos con los servicios de emergencia. Sin embargo, nuestra máxima prioridad será el bienestar inmediato de su hijo. Usted será económicamente responsable del tratamiento médico que se le dé a su hijo.

Permiso para ver películas

☐ Doy / ☐ **No doy** permiso para que mi hijo vea películas con clasificación PG durante la clase. Las películas están específicamente elegidas para coordinarse con el programa de estudios de cada grado. El maestro habrá visto previamente las películas para asegurarse de que sean apropiadas para reproducirlas en la escuela.

Nombre del estudiante	Grado
Firma del padre de familia o tutor	Fecha
Nombre en letra de molde del padre de familia o tutor	Relación con el estudiante

¡¡LLENE Y DEVUELVA A LA ESCUELA EN LA QUE SE INSCRIBIRÁ - OBLIGATORIO PARA TODOS LOS ESTUDIANTES!!

Voluntary Student Accident Insurance

2021-2022
NATIONAL

Health Special Risk, Inc.
HSR Plaza II
4100 Medical Parkway
Carrollton, TX 75007-1517

Phone: 866.409.5733, Ext. 5660
Fax: 972.512.5819
www.healthspecialrisk.com




HSR is an independent licensed insurance agency and is authorized to sell this student accident insurance on behalf of Mutual of Omaha Insurance Company.

Coverage underwritten by: Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175.

HSR Health Special Risk, Inc.

Mutual of Omaha

MUGC9641

NAT'L Hi-Lo Policy Form SR2014

NATIONAL
2021-2022
K-12 Voluntary Student Accident Insurance Coverage
(Not Available in AR, FL, ID, KS, KY, MD, MT, NC, NH, NY, SD, TX, & WA)

Coverage underwritten by: Mutual of Omaha Insurance Company; 3300 Mutual of Omaha Plaza; Omaha, NE 68175

ELIGIBILITY:
All registered students grades PreK-12 of a participating school/district.

COVERAGE OPTIONS
AT SCHOOL COVERAGE: Insurance coverage is provided during the hours and days when school is in session, while attending or participating in school sponsored and supervised activities on or off school premises (i.e. day field trips) and while participating in interscholastic athletics (except injuries incurred while participating in High School Football events/activities). Coverage is provided while traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from the Insured's home premises and school premises when school is in session. If the Policyholder provides mandatory coverage for students under an At School, Interscholastic Athletic/Activity or Football program, benefits will be payable under those programs before being considered under an At School Voluntary program.

24-HOUR COVERAGE: Provides coverage for injuries incurred 24-Hours a day, 365 days a year, at home, at school and while participating in interscholastic athletics (except injuries incurred while participating in High School Football events/activities). If the Policyholder provides mandatory coverage for students under an Interscholastic Athletic/Activity, Football or At School program, benefits will be payable under those programs before being considered under a 24-Hour Voluntary program.

FOOTBALL ONLY: Insurance coverage is provided for High School Football athletes during athletic tryouts, preseason play, practice, state interscholastic governing body approved conditioning, regular and post season play and for travel to, during or after covered athletic activities as a member of a group in transportation furnished and arranged by the school. If the Policyholder provides mandatory coverage for Football athletes under an Interscholastic Athletic/Activity or Football program, benefits will be payable under those programs before being considered under a Voluntary Football Only program.

EXTENDED DENTAL COVERAGE: This is supplemental coverage for expenses resulting from covered accidental dental injuries. The dental benefits provided are: (a) 100% of Allowable Expense for examinations, X-Rays, endodontics and oral surgery to a maximum of $10,000; or (b) dental expenses toward the cost of bridges, dentures or replacement of previous dental repairs to a maximum of $250. No coverage is provided for orthodontics (braces) for any reason or damage or loss thereof. Extended Dental Coverage must be purchased in conjunction with a 24-Hour, At School or Football program; it cannot be purchased as stand alone coverage.

COVERAGE PERIOD – Coverage under the At School, 24-Hour and Football programs begins on the date of premium receipt but not before the start of the school year activities. At School Coverage ends at the close of the regular nine-month school term. 24-Hour Coverage ends when school reopens for the following fall term. Coverage is available under both plans throughout the school year at the premiums quoted **(no pro rata premiums available).**

BENEFITS
ACCIDENT MEDICAL EXPENSE: When a covered injury to an Insured results in treatment by a physician or surgeon beginning within 60 days of the date of the accident; we will pay benefits as shown in the **Schedule of Benefits**, in excess of the Medical Deductible, if any. Only eligible medical expenses incurred by the Insured within 52 weeks from the date of the accident are covered. Benefits for any one accident shall not exceed in the aggregate the maximum Medical Benefit of $25,000. We will pay the Medical Expenses an Insured incurs for covered services that exceed amounts payable by any Other Insurance Plan, subject to the Deductible, Benefit Percentage, and Benefit Period.

ACCIDENTAL DEATH AND SPECIFIC LOSS: Benefits are paid for losses incurred within 180 days from the date of Injury. The following benefits (the largest applicable amount) are paid in addition to the medical benefit:

Loss of Life	$10,000.00
Loss of both hands, both feet, sight in both eyes, speech and hearing	$10,000.00
Loss of one hand, one foot, sight in one eye, speech or hearing	$5,000.00
Loss of Thumb and Index Finger of the Same Hand	$500.00

"Loss" means, with regard to hands and feet, actual severance above the wrist or ankle joint, with regard to sight, speech or hearing the total and irrevocable loss thereof. Loss means, with regard to thumb and index finger of the same hand, severance of two or more entire phalanges of both the thumb and index finger.

DEFINITIONS

Allowable Expense means a Medical Expense otherwise payable under the policy that is not in excess of the 80th percentile identified on Context4HealthCare (the "Database"). When there is, in Our determination, minimal data available from the Database for a Medical Expense, We will determine the amount to pay by calculating the unit cost for the applicable service category using the Database and multiplying that by the relative value of the Medical Expense based upon a commercially available relative value scale selected by Us. In the event of an unusually complex medical procedure, a Medical Expense for a new procedure or a Medical Expense that otherwise does not have a relative value that is in Our determination applicable, We will assign a relative value. The Medical Expenses We pay may not reflect the actual charges of a provider and does not take into account the provider's training, experience or category of licensure. A provider may charge the Insured the difference between what the provider charges and the amount We pay under the policy. The Database will be updated by us as information becomes available from the supplier, up to twice each year. We may modify the Database in Our discretion to reflect Our experience. We have the right, in Our discretion, to substitute or replace the Database with another database or databases of comparable purpose, with or without notice.

Injury means bodily harm which: (1) requires treatment by a Physician; (2) results in loss due to an Accident, independent of Sickness and all other causes; and (3) occurs within the Scope of Coverage.

Hospital means an institution which: (1) is operated pursuant to law; (2) is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis; (3) is under the supervision of a staff of Physicians; (4) provides 24-hour nursing service by or under the supervision of a graduate registered nurse (R.N.); and (5) has medical, diagnostic and treatment facilities, with major surgical facilities on its premises or available to it on a prearranged basis. Hospital does not include: (1) a clinic or facility for: (a) convalescent, custodial, educational or nursing care; (b) the aged, drug addicts or alcoholics; (c) rehabilitation; or (2) a military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless: (a) the services are rendered on an emergency basis; and (b) the individual has a legal liability to pay for the services given in the absence of insurance.

EXCLUSIONS AND LIMITATIONS

We will not pay benefits for a loss due to or expenses incurred for:

(1) intentionally self-inflicted injury, suicide while sane or insane; (2) voluntary self-administration of any drug or chemical substance not prescribed by or not taken according to the directions of the Insured's Physician; (3) Injury caused by, attributable to, or resulting from the Insured's Intoxication; (4) Injury caused by, attributable to, or resulting from the Insured's use of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage; (5) operating a motor vehicle under the influence of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage; (6) operating a motor vehicle while having a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred; (7) commitment of or an attempt to commit a felony, or engagement in an illegal activity; (8) participation in a riot or insurrection; (9) any Injury that results from fighting, brawling, assault or battery; (10) an act of declared or undeclared war; (11) active duty service in any Armed Forces; (12) operating, learning to operate, or serving as a pilot or crew member of any aircraft unless specified in the INSURED RISKS section of this policy; (13) mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment); (14) parachuting, except for self-preservation; (15) snow skiing, scuba diving, bob-sledding, bungee jumping, ballooning, flight in an ultralight aircraft, sky diving, hang-gliding, glider flying, sailplaning, or parasailing; (16) participation in professional or amateur racing; (17) injuries associated with activities or travel outside the United States; (18) sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not exclude bacterial infection that is the natural and foreseeable result of an Injury or accidental food poisoning; (19) dental treatment or dental X-rays, except as otherwise provided, and only when Injury occurs to sound natural teeth; (20) orthodontic braces or appliances; (21) any loss for which benefits are paid under state or federal worker's compensation, employers' liability, or occupational disease law; (22) charges which the Insured would not have to pay if the Insured did not have insurance; (23) a charge which is in excess of the Allowable Expense; (24) cosmetic surgery, except reconstructive surgery due to a covered Injury; (25) participation in semi-professional and professional sports, play or practice, or any related travel; (26) participation in practice or play of any sports activity, including travel to and from games and practice, unless specified in this policy; (27) assistant surgeon services, unless specified in this policy; (28) elective treatment or surgery that is not prescribed by a Physician and is not Medically Necessary, health treatment, or examination where no Injury is involved; (29) Pre-existing Conditions; (30) any Heart or Circulatory Malfunction; (31) loss caused by or resulting from nuclear radiation or the release of nuclear energy; (32) services or treatment incurred to the extent that they are paid or payable under any Other Insurance Plan; (33) services or treatment incurred to the extent that they are paid or payable under any automobile insurance policy without regard to fault. This exclusion does not apply in any state where it is prohibited; (34) travel in or upon: (a) a snowmobile; (b) any two or three wheeled motor vehicle; (c) any off-road motorized vehicle not requiring licensing as a motor vehicle in the jurisdiction where operated; (35) any Accident in which the Insured is operating a motor vehicle without a current and valid motor vehicle operator's license (except in a driver's education program); (36) treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy.

NATIONAL
VOLUNTARY STUDENT ACCIDENT INSURANCE
SCHEDULE OF BENEFITS

INPATIENT:	**LOW OPTION**	**HIGH OPTION**
Room & Board	**Semi-Private Room Rate/$150 per day maximum**	**80% of Allowable Expense/Semi-Private Room Rate**
Hospital Miscellaneous	**Up to $600 per day maximum**	**Up to $1,200 per day maximum**
Registered Nurse	**75% of Allowable Expense**	**100% of Allowable Expense**
Physician's Nonsurgical Visits	**Up to $40 first day; $25 per day thereafter**	**Up to $60 first day; $40 per day thereafter**
(Benefits are limited to one visit per day and do not apply when related to surgery)		
OUTPATIENT:		
Hospital Outpatient Surgery – Facility Charge	**Up to $1,000 maximum**	**Up to $1,200 per day maximum**
Physician's Nonsurgical Visits	**Up to $40 first day; $25 per day thereafter**	**Up to $60 first day; $40 per day thereafter**
(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)		
Physiotherapy	**Up to $30 first day; $20 per day thereafter/5 day maximum**	**Up to $60 first day; $40 per day thereafter/5 day maximum**
Emergency Room	**Up to $150 maximum**	**Up to $300 maximum**
(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)		
X-Ray Services (Includes charges for reading)	**$200 maximum**	**$600 maximum**
Diagnostic Imaging - Cat Scan/MRI (includes charges for reading)	**$300 maximum**	**$600 maximum**
Laboratory	**$50 maximum**	**$300 maximum**
Injections	**Up to $25/injury**	**Up to $25/injury**
Prescription Drugs	**$75 maximum**	**$200 maximum**
Orthopedic Braces and Appliances	**$75 maximum**	**$140 maximum**
INPATIENT AND/OR OUTPATIENT:		
Surgeon's Fees	**$1,000 maximum. (No more than one procedure through the same incision will be paid)**	**$1,200 maximum. (No more than one procedure through the same incision will be paid)**
Anesthetist/Assistant Surgeon	**20% of surgeon's allowance**	**25% of surgeon's allowance**
Ambulance	**$300 maximum**	**$800 maximum**
Consultant	**$200 maximum**	**$400 maximum**
Treatment of Heat Exhaustion	**100% of Allowable Expense**	**100% of Allowable Expense**
Dental	**Up to $200 per tooth (Benefits are paid on sound natural teeth only)**	**Up to $500 per tooth (Benefits are paid on sound natural teeth only)**
Replacement of Eyeglasses, Contact Lenses and Hearing Aids	**$200 maximum (When broken as a result of a covered injury)**	**$300 maximum (When broken as a result of a covered injury)**

PLAN & RATE OPTIONS

(Make your selection on the enrollment form attached).

COVERAGE PLANS	LOW OPTION RATES	HIGH OPTION RATES
24-Hour	$ 86.65	$132.65
24-Hour Summer Only	$ 22.45	$ 35.30
At School	$ 21.40	$ 31.00
High School Football	$147.65	$230.05
Spring High School Football	$ 58.85	$ 92.00
Extended Dental	$ 9.65	$ 9.65

RETAIN THIS DESCRIPTION FOR YOUR RECORDS. Retain this student accident insurance flyer, and your canceled check, money order receipt or credit card receipt as your record of coverage. This flyer has been designed to illustrate the highlights of this insurance. All student accident insurance information is subject to the provisions of Policy Form SR2014 and state special versions. Exclusions and Limitations will apply. Should there be any discrepancy between the policy and this student accident information, policy provisions will prevail.

HSR
Health Special Risk, Inc.

2021-2022
VOLUNTARY
STUDENT ACCIDENT INSURANCE
ENROLLMENT FORM
(Not Available in AR, FL, ID, KS, KY, MD, MT, NC, NH, NY, SD, TX, & WA)

Student's Last Name:_____ Student's Date of Birth:_____

Student's First Name:_____ MI:_____ Telephone Number:_____

Student's Social Security Number:_____ Grade:_____ Student ID Number:_____

Address:_____
Street City State Zip

Name of School District:_____ Name of School Campus:_____
(**Required to Process**)

Signature of Parent or Guardian:_____ Date:_____ E-mail Address:_____

PLEASE CHECK YOUR SELECTION BELOW:		
COVERAGE PLANS	LOW OPTION	HIGH OPTION
24-Hour	☐ $ 86.65*	☐ $132.65*
24-Hour Summer Only	☐ $ 22.45*	☐ $ 35.30*
At School	☐ $ 21.40*	☐ $ 31.00*
High School Football	☐ $147.65*	☐ $230.05*
Spring High School Football	☐ $ 58.85*	☐ $ 92.00*
Extended Dental	☐ $ 9.65*	☐ $ 9.65*
COMPANY USE ONLY: Check # _____ Amount Rec'd _____		**Enclose check for total amount payable to: Health Special Risk** TOTAL All Selections HERE: $_____

***There is a $1.00 administration fee due with each paper enrollment form submission.**

Once completed, mail this form to:

Health Special Risk, Inc.
P.O. Box 957824
St. Louis, MO 63195-7824

For more information or assistance regarding all Student Insurance, contact our Customer Service Department at **1-866-409-5733**

IF YOU WISH TO PAY WITH MASTERCARD OR VISA: Go to www.K12StudentInsurance.com**

*****A 5% administrative charge will be added for Credit Card Orders***

Accident Coverage underwritten by: Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175

Seguro Voluntario de Accidentes para Estudiantes

NATIONAL 2021-2022

Health Special Risk, Inc.
HSR Plaza II
4100 Medical Parkway
Carrollton, TX 75007-1517

Teléfono: 866.409.5733, ext. 5660
Fax: 972.512.5819




HSR es una agencia con licencia de seguros independiente y está autorizada para vender seguro de accidentes para estudiantes a nombre de la Compañíade Seguros Mutual of Omaha.

Cobertura suscrita por: Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175.

HSR Health Special Risk, Inc.

Mutual of Omaha

MUGC9642

Nat'l Hi-Lo

Policy Form SR2014

A NIVEL NACIONAL

2021-2022

Cobertura de Seguro Voluntario de Accidente para Estudiantes de K-12

(No esta disponible en los siguientes estados: AR, FL, ID, KS, KY, MD, MT, NC, NH, NY, SD, TX, y WA

Cobertura Suscrita por: Mutual of Omaha Insurance Company; 3300 Mutual of Omaha Plaza; Omaha, NE 68175

ELEGIBILIDAD:

Todos los alumnos matriculados en una escuela/distrito participante en los grados de Pre-kínder hasta el grado 12

OPCIONES DE COBERTURA

COBERTURA EN LA ESCUELA: Se proveerá la cobertura del seguro durante las horas y días en que la escuela está en sesión, mientras este asistiendo a la escuela o participando en actividades patrocinadas y supervisadas dentro o fuera de las instalaciones de la escuela (por ejemplo, viajes a excursiones "field days") y mientras participa actividades deportivas inter-escolares (con la excepción de lesiones sufridas durante su participación en eventos/actividades de Fútbol Americano de escuela secundaria). Se proporciona cobertura mientras viaje a, durante o después de tales actividades como miembro de un grupo de transporte proporcionado u organizado por el Tenedor de la Póliza y viajando directamente hacia o desde los predios de su residencia o los predios de la escuela cuando la escuela está en sesión. Si el Tenedor de Póliza proporciona cobertura obligatoria para los estudiantes bajo el Programa de Actividades Atléticas o Programa de Fútbol Americano Inter-escolares, los beneficios se pagarán primero bajo tales programas antes de ser considerados bajo un Programa Voluntario de En La Escuela.

COBERTURA LAS 24 HORAS: Proporciona cobertura por lesiones sufridas las 24 horas del día, los 365 días del año, en casa, en la escuela y durante su participación en actividades deportivas inter-escolares (con la excepción de lesiones sufridas durante su participación en eventos/actividades de Fútbol Americano de escuela secundaria). Si el Tenedor de la Póliza proporciona cobertura obligatoria para los estudiantes bajo un programa de Fútbol Americano, programa Atlético/Actividad Inter-escolar, o un Programa de en la Escuela, los beneficios se pagarán bajo tales programas antes de ser considerados bajo el programa Voluntario de 24 horas.

SOLO PARA FÚTBOL AMERICANO : Se proporcionará cobertura de seguro a los atletas de Fútbol Americano de escuela secundaria ya sea para las actividades aprobado por los gobernantes inter escolares del estado tales como pruebas de selección ("tryouts"), juego de pretemporada, práctica, acondicionamiento físico, juego de temporada regular, juegos de post temporada, así como los viajes a, durante o después de las actividades atléticas como miembro del equipo cuando la transportación es proporcionado y organizado por la escuela. Si el Tenedor de la Póliza proporciona cobertura obligatoria para los atletas de fútbol americano bajo un programa Atlético/Actividad Inter-escolar de Fútbol Americano, se pagarán beneficios bajo esos programas antes de ser consideradas bajo un programa Voluntario de Fútbol Americano.**COBERTURA DENTAL EXTENDIDA**: Esta es una cobertura adicional para los gastos incurridos por accidentes dentales que estén cubiertos. Los beneficios dentales proporcionados son: (a) el 100% de los cargos permitidos para exámenes, radiografías, endodoncia y cirugía oral hasta un máximo de $10,000; O (b) los gastos dentales que sean para puentes, dentaduras postizas o el reemplazo de las reparaciones dentales anteriores a un máximo de $250. No se proporcionará cobertura para frenillos ortodonticos (braces) por ninguna razón o daño o pérdida de los mismos. Cobertura dental extendida se debe comprar junto con uno de los siguientes programas, coberturas de 24 Horas, En La Escuela o de Fútbol Americano; no podrá ser adquirido como una cobertura independiente.

PERIODO DE COBERTURA - La cobertura bajo los programas tales como En La Escuela, Las 24 Horas y de Fútbol Americano comienzan a partir de la fecha que se recibe la prima, pero no antes del inicio de las actividades del año escolar. La cobertura de En La Escuela termina al cierre del período regular de nueve meses de la escuela. La cobertura de Las 24 Horas termina cuando la escuela abre nuevamente en otoño. La cobertura está disponible para ambos planes a través de todo el año escolar de acuerdo a las primas cotizadas **(no hay primas pro rata disponibles).**

BENEFICIOS

GASTOS MÉDICOS DE ACCIDENTES: Cuando le sucede una lesión cubierta a un asegurado y esa lesión resulta en tratamiento ya sea por un médico o cirujano dentro de los 60 días de la fecha del accidente; nosotros pagaremos los beneficios como se muestra en la Tabla de Beneficios, después del deducible médico, si los hubiere. Sólo aquellos gastos médicos elegibles incurridos por el Asegurado dentro de las 52 semanas desde la fecha del accidente están cubiertos. Los beneficios para un accidente singular no podrán exceder el beneficio médico máximo de $25,000 en su totalidad.

MUERTE ACCIDENTAL Y PÉRDIDA ESPECÍFICA: Se pagaran beneficios por las pérdidas sufridas dentro de los 180 días desde el día lesión. Los siguientes beneficios (la mayor cantidad que aplique) se pagaran además del beneficio médico:

Pérdida de la Vida	$10,000.00
Pérdida de ambas manos, ambos pies, la vista en ambos ojos, el habla y la audición	$10,000.00
Pérdida de una mano, un pie, la vista en un ojo, el habla o la audición	$5,000.00
Pérdida del dedo pulgar e índice de la misma mano	$500.00

"Pérdida" significa, en relación con las manos y los pies, la desmembración por más allá de la muñeca o el tobillo, con respecto a la vista, el habla o la audición la pérdida total e irrevocable de los mismos. Con respecto al pulgar y el dedo índice de la misma mano, pérdida también significa, la ruptura o el desprendimiento de dos o más falanges enteras de tanto el pulgar y el dedo índice.

DEFINICIONES

Gastos Permitidos significa un gasto médico que de otra manera es pagado bajo la póliza que no está en exceso del 85 porciento identificado en Context4HealthCare (la " Base de datos"). Cuando exista, a nuestra determinación, un mínimo de datos disponibles en la base de datos para un gasto médico, determinaremos la cantidad a pagar calculando el costo unitario de la categoría de servicios aplicable utilizando la Base de Datos y multiplicándolo por el valor determinado de la gastos Médicos basado en una escala de valor comercial determinado disponibles que nosotros seleccionemos. En caso de un procedimiento médico inusualmente complejo, el costo de un nuevo procedimiento medico o el Gasto de un Servicio Medico que no tenga un valor determinado que tengamos que hacer una determinación, nosotros le asignaremos un valor fijo. Los Gastos Médicos que nosotros paguemos pueden que no reflejen los cargos reales de un proveedor y no tiene en cuenta la capacitación de los proveedores, la experiencia o la categoría de la licencia. Un proveedor puede cobrarle al Asegurado la diferencia entre lo que cobra el proveedor y la cantidad que nosotros paguemos bajo la póliza. Nosotros actualizaremos la base de datos tal como la información sea proveída por el médico, hasta dos veces al año. Podremos modificar la base de datos a Nuestra discreción para reflejar nuestras experiencias anteriores. Tenemos el derecho, a nuestra discreción, de sustituir o reemplazar la base de datos con otra(s) base(s) de datos que sean similarmente comparativos, con o sin previo aviso.

Lesión es el daño corporal o físico que (1) requiere tratamiento de un médico; (2) resulte en una pérdida debido a un accidente, independientemente de la enfermedad y otras causas; y (3) pase en el periodo de tiempo que este asegurado bajo la cobertura.

Hospital significa una institución que: (1) es operada de acuerdo a la ley; (2) la responsabilidad primaria este vinculada con el cuidado, atención medica, y el tratamiento de personas enfermas y lesionadas como pacientes hospitalizados; (3) está bajo la supervisión de un equipo de Médicos; (4) dispone de servicio de enfermería las 24 horas por o bajo la supervisión de una enfermera(o) graduada(o) registrada(o) (RN siglas en inglés); y (5) cuenta con instalaciones médicas, de diagnóstico y tratamiento, con facilidades de quirófanos en sus localidades o que disponga de forma preestablecida. El Hospital no incluye: (1) una clínica o facilidad de: (a) convalecencia, custodia, educación o cuidado de enfermería; (b) los mayores de edad, adictos a drogas o alcohólicos; (c) rehabilitación; o (2) un hospital militar o de veteranos o un hospital contratado o administrado por el gobierno o sus agencias a menos que: (a) los servicios sean prestados en casos de emergencia; y (b) la persona sea responsable legalmente de pagar por los servicios prestados en la ausencia de un seguro.

EXCLUSIONES Y LIMITACIONES

No pagaremos los beneficios de una pérdida causada por o para gastos incurridos de lo siguiente: (1) Lesiones auto infligidas intencionalmente, suicidio mientras esté cuerdo o demente; (2) Administración auto voluntaria de cualquier droga o sustancia no prescrita o no tomadas según las instrucciones del médico del Asegurado; (3) Daño causado por, atribuible a, o como resultado de la intoxicación del Asegurado; (4) Daños causado por, atribuible a, o como resultado de su uso del Asegurado de una sustancia controlada a menos que se administre por consejo de un médico y tomando la dosis prescrita; (5) Manejar un vehículo de motor bajo la influencia de una sustancia controlada a menos que se administra en el consejo de un médico y tomando la dosis prescrita; (6) Manejar un vehículo de motor mientras tenga un nivel de alcohol en sangre igual o superior al límite legal para operar un vehículo de motor en el estado o jurisdicción donde ocurrió la lesión; (7) El compromiso o un intento de cometer un delito grave, o la participación en una actividad ilegal; (8) La participación en una disturbio o insurrección; (9) Cualquier daño que resulte de peleas, asalto o agresión; (10) Un acto de guerra declarada o no; (11) El servicio activo en las Fuerzas Armadas; (12) Volar, aprendiendo a volar o servir como piloto o miembro de la tripulación de cualquier aeronave a menos que se especifique en la sección de RIESGOS DEL ASEGURADO de esta póliza; (13) Alpinismo (la participación en el deporte de escalar montañas generalmente requiere el uso de picos, cuerdas y otros equipos especiales); (14) Paracaidismo, excepto para instinto de sobrevivencia; (15) Esquiar en la nieve, buceo, bobsleading (trineo de carreras), puentismo, vuelo en globo, vuelo en un avión ultraligero, paracaidismo, hang-gliding (parapente), vuelo en planeador, sailplaning (planeador ligero) o paravela; (16) La participación en las carreras profesionales o aficionados; (17) Lesiones relacionadas con actividades o viajes fuera de los Estados Unidos;(18) Enfermedad, dolencia, corporal o trastorno mental o el tratamiento médico o quirúrgico de la misma, una infección bacteriana o viral, independientemente de cómo sea contraído. Esto no excluye la infección bacteriana que es el resultado natural y previsible de una lesión o envenenamiento accidental de los alimentos; (19) Tratamiento dental o rayos-X dentales, salvo estipulado de otra manera y sólo cuando se produce una lesión a dientes naturales que estén sanos; (20) Cualquier pérdida por la cual los beneficios se pagan bajo las leyes estatales o federales de compensación del trabajador, de responsabilidad del empleador o de enfermedades ocupacionales; (21) Los cargos por los que el asegurado no tendrían que pagar si el asegurado no tuviese un seguro; (22) Un costo más allá del costo admisible; (23) Cirugía cosmética, con la excepción de la cirugía reconstructiva debido a una lesión que este bajo la cobertura; (24) Participación en los deportes semi-profesionales y profesionales, el juego o práctica, o cualquier viaje relacionado a ello; (25) La participación en la práctica o el juego de cualquier actividad deportiva, incluyendo los viajes hacia y desde los juegos y las prácticas, a menos que se especifique en esta póliza; (26) Servicios de cirujano auxiliar, a menos que se especifican en esta póliza; (27) Tratamiento electivo o cirugía que no sean aconsejado por un médico y que no sea médicamente necesario, también tratamiento médico o exanimación donde no este envuelta la lesión; (28) Condiciones pre-existentes; (29) Virus de la inmunodeficiencia humana (VIH), el síndrome de inmunodeficiencia adquirida (SIDA) o complejo relacionado con SIDA (ARC siglas en inglés); (30) Cualquier mal funcionamiento del corazón o sistema circulatorio; (31) Pérdida causada por o como resultado de radiación nuclear o fuga de energía nuclear; (32) Servicios o tratamientos efectuados que son pagados o pagaderos bajo cualquier otro plan de seguro; (33) Servicios o tratamientos efectuados que son pagados o pagaderos bajo cualquier póliza de seguro de automóvil, sin admitir responsabilidad. Esta exclusión no aplica a aquellos estados donde este prohibido; (34) Viajar en o sobre: (a) Una moto de nieve; (b) Cualquier vehículo de motor de dos o tres ruedas; (c) Cualquier vehículo todo terreno motorizado que no requiera licencia para manejar vehículo de motor en la jurisdicción donde opera; (35) Cualquier accidente en el que el asegurado está operando un vehículo de motor sin licencia de operador de vehículo de motor vigente y válido (excepto en el programa de educación de conducir); (36) Anteojos, lentes de contacto, aparatos auditivos, o exámenes o prescripciones relacionadas; (37) Tratamiento por trauma debido a articulación temporo-andibular (ATM) que involucra la instalación de coronas, pónticos, puentes o pilares o la instalación, el mantenimiento o la eliminación de los aparatos de ortodoncia u oclusores o terapia de equilibrio.

GUARDE ESTA DESCRIPCIÓN EN SUS RECORDS. Conserve este folleto de seguro accidental con su cheque cancelado, recibo de giro postal o recibo de tarjeta de crédito como acuse de recibo de la cobertura. Este folleto ha sido diseñado para ilustrar los aspectos más destacados de este seguro. Toda la información del seguro accidental para el estudiante está sujeta a las disposiciones de la Póliza SR2014. Las exclusiones y limitaciones serán aplicadas. Si hubiera alguna discrepancia entre la póliza y esta información de accidente para el estudiante, las disposiciones de la póliza prevalecerán.

La póliza o certificado de seguro que tienen que ver con la cobertura y los servicios descritos en este anuncio serán proveídos en inglés solamente. Toda documentación, avisos y comunicaciones de apoyo que estén relacionado también se proporcionarán solamente en inglés. Le recomendamos que busque asistencia de un traductor y/o interprete. No obstante, las pólizas y certificados de seguro están disponibles en español para los residentes de Puerto Rico que lo soliciten.

COBERTURA DE SEGURO VOLUNTARIO DE ACCIDENTES PARA LOS ESTUDIANTES DE EL RESTO DE LA NACION
PROGRAMA DE BENEFICIOS

PACIENTES HOSPITALIZADOS:	**OPCIÓN – BAJA**	**OPCIÓN – ALTA**
Alojamiento y Comida / Misceláneos de Hospital	Tarifa de habitación semi - privada / máximo de $150 por día	80% de la Tarifa Usual y Acostumbrada por Una Habitación Semi - privada
Misceláneos de Hospital	Hasta un máximo de $600 por día	Hasta un máximo de $1,200 por Día
Enfermera Registrada o Graduada	75% de los habituales	100% de los habituales
Visitas del Médico No Quirúrgicas	Hasta $40 el primer día; $25 por día a partir de entonces	Hasta $60 el primer día; $40 por día a partir de entonces
(Los beneficios se limitan a una visita por día y no se aplican cuando se relaciona con una cirugía)		
PACIENTES AMBULATORIOS:		
Costo de Cirugía Ambulatoria-Cargos por Instalación Médica	Hasta un Máximo de $1,000	Hasta un Máximo de $1,200
Visitas del Médico No Quirúrgicas	Hasta $40 el primer día; $25 por día a partir de entonces	Hasta $60 el primer día; $40 por día a partir de entonces
(Los beneficios se limitan a una visita por día y no se aplican cuando se relaciona con la cirugía o fisioterapia)		
Fisioterapia	Hasta $30 el primer día; $20 por día a partir de entonces / 5 días máximos	Hasta $60 el primer día; $40 por día a partir de entonces /5 días máximos
Sala de Emergencia	Hasta un Máximo de $150	Hasta un Máximo de $300
(Uso de la sala y materiales, el tratamiento debe ser dado dentro de 72 horas desde el momento de la lesión)		
Servicios de Rayos X - (Incluye cargos por lectura)	Máximo de $200	Máximo de $600
Cat Scan /MRI	Máximo de $300	Máximo de $600
Laboratorio	Máximo de $50	Máximo de $300
Inyecciones	Hasta $25, lesión	Hasta $25, lesión
Medicamentos con Receta	Máximo de $75	Máximo de $200
Aparatos y Accesorios Ortopédicos	Máximo de $75	Máximo de $140
PACIENTES HOSPITALIZADOS Y/O AMBULATORIOS:		
Honorarios del cirujano	Máximo de $1,000 (No se pagaran procedimientos adicionales por la misma incisión)	Máximo de $1,200 (No se pagaran procedimientos adicionales por la misma incisión)
Anestesista	20% del gasto permitido para el cirujano	25% del gasto permitido para el cirujano
Ambulancia	Máximo de $300	Máximo de $800
Consultor	Máximo de $200	Máximo de $400
Tratamiento del agotamiento por calor	100% de los habituales	100% de los habituales
Dental	Hasta $200 por diente (Los beneficios se pagan en los dientes naturales y sanos solamente)	Hasta $ 500 por diente (Los beneficios se pagan en los dientes naturales y sanos solamente)
El reemplazo de anteojos, lentes de contacto y audífonos	Máximo de $200 (Al romperse como resultado de una lesión en la cubierta)	Máximo de $300 (Al romperse como resultado de una lesión en la cubierta)

TIPOS DE OPCIONES

(Haga su selección en el formulario de inscripción adjunto).

PLANES DE COBERTURA	OPCIÓN – TARIFA BAJA	OPCIÓN – TARIFA ALTA
24 Horas	$ 86.65	$132.65
24 Horas Veranos Solamente	$ 22.45	$ 35.30
En La Escuela	$ 21.40	$ 31.00
Fútbol Americano Escuela Secundaria	$147.65	$230.05
Fútbol Americano Primaveral Escuela Secundaria	$ 58.85	$ 92.00
Dental Extendido	$ 9.65	$ 9.65

2021-2022
SEGURO VOLUNTARIO
DE ACCIDENTE PARA ESTUDIANTES
FORMULARIO DE SUSCRIPCIÓN

(No esta disponible en los siguientes estados: AR, FL, ID, KS, KY, MD, MT, NC, NH, NY, SD, TX, & WA)

Apellido del Estudiante:_____ Fecha de Nacimiento del Estudiante:_____

Nombre del Estudiante:_____ Inicial:_____ Numero de Teléfono:_____

Número de Seguro Social del Estudiante:_____ Grado:_____ Número de Identificación del Estudiante:_____

Número de la Calle:_____
Dirección Ciudad Estado Código Postal

Nombre del Distrito Escolar:_____ Nombre de la Escuela/Campus:_____
(**Requerido para Procesar**)

Firma del Padre o Guardián:_____ Fecha:_____ E-mail Address:_____

POR FAVOR SELECCIONE SU PLAN A CONTINUACION:

PLANES DE COBERTURA	OPCIÓN BAJA	OPCIÓN ALTA
24-Hour (24 Horas)	☐ $ 86.65*	☐ $132.65*
24-Hour (24 Horas, Solamente en Verano)	☐ $ 22.45*	☐ $ 35.30*
At School (En la Escuela)	☐ $ 21.40*	☐ $ 31.00*
High School Football (Fútbol Americano a Nivel de Secundaria)	☐ $147.65*	☐ $230.05*
Spring High School Football (Fútbol Americano en Primavera a Nivel de Secundaria)	☐ $ 58.85*	☐ $ 92.00*
Extended Dental (Seguro Dental Extendido)	☐ $ 9.65*	☐ $ 9.65*
SOLAMENTE PARA USO DE LA COMPAÑÍA: Número de cheque _____ Cantidad Recibida _____	**Adjuntado se encuentra el cheque de pago total pagadero a: Health Special Risk** TOTAL de todas las elecciones AQUI: $_____	

*** Existe un cargo adicional de proceso de $1.00 por cobertura comprada para procesar el papeleo.**

Una vez completado, envíe este formulario a:

Health Special Risk, Inc.
P.O. Box 957824
St. Louis, MO 63195-7824

Para más información referente a Seguro de Estudiantes, comuníquese con el Departamento de Servicio al Cliente al **1-866-409-5733**

IF YOU WISH TO PAY WITH MASTERCARD OR VISA: Go to www.K12StudentInsurance.com**

*****A 5% administrative charge will be added for Credit Card Orders***

Cobertura de Accidente Suscrita por: Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175

ATTENTION PARENTS AND GUARDIANS
Supplemental Student Accident Insurance is Now Available

Health Special Risk, Inc. is offering two options for supplemental student accident insurance.

AT-SCHOOL COVERAGE

At-School coverage provides protection for students enrolled full time in Kindergarten through 12th grade during regular school hours for the entire school year.

24-HOUR COVERAGE

This coverage provides protection 24 hours a day, seven days a week for any covered student accident that occurs anywhere, not just on school grounds.

The premium for either option is paid annually. This one-time payment provides coverage for the entire year. Both coverage options provide protection beginning from the date of enrollment in the plan.

Supplemental student accident insurance is applicable for any covered activity. Certain exclusions and limitations apply. Please read the policy information carefully for an overview of the plan. If you wish to purchase this coverage, here's how to enroll:

Go to: www.K12StudentInsurance.com

New Visitors

1. Browse rates
2. Open a new account – Once you've determined your school is covered, you'll need to open a new account and add student and coverage
3. Add student(s) and coverage on the MyAccount page

Returning Account Holders

1. MyAccount Logon
2. Maintain Student Data
3. Maintain Insurance Coverage

For information or assistance regarding all student insurance, contact our customer service department at (866) 409-5733.

Underwritten by Mutual of Omaha Insurance Company,
3300 Mutual of Omaha Plaza, Omaha, NE 68175.
Policy Form T5MP Series 6440S NC; Series 6754S FL
Policy Form B33MP Series 8408S TX
Policy Form SR2014 TX
Riders: 868MS-EZ, 0KV5M, 6785M, 0CX5M, 867MS-EZ, 6773M, 0KV4M, 1359MS-EZ, 6653M, 850MS-EZ, 851MS-EZ, 6425M Rev 04-10, 0LJ8MS, 9130MS, 6925M, 1364MS, 0LC7M.

Mutual of Omaha | HSR Health Special Risk, Inc.

ATENCIÓN, PADRES Y GUARDIANES
Ahora está disponible el Seguro contra accidentes estudiantiles adicional

Health Special Risk, Inc. ofrece dos opciones de seguro contra accidentes estudiantiles adicional.

COBERTURA EN LA ESCUELA

La cobertura en la escuela brinda cobertura para los estudiantes inscritos tiempo completo en Kindergarten hasta el grado 12 durante el horario normal de escuela para todo el ciclo lectivo.

COBERTURA LAS 24 HORAS

Esta cobertura brinda protección las 24 horas al día, los siete días de la semana, para cualquier accidente estudiantil cubierto que ocurra en cualquier lugar, no solo en el territorio de la escuela.

La prima para cualquiera de las dos opciones se paga anualmente. Este pago único ofrece cobertura para todo el año. Ambas opciones de cobertura ofrecen protección desde la fecha de inscripción en el plan.

El seguro contra accidentes estudiantiles adicional es aplicable a cualquier actividad cubierta. Se aplican ciertas exclusiones y limitaciones. Lea cuidadosamente la información de la póliza para ver una descripción general del plan. Si desea comprar esta cobertura, esta es la forma de inscribirse:

Vaya a: www.K12StudentInsurance.com

Nuevo visitante (New Visitors)

1. Buscar tarifas (Browse Rates)
2. Abrir una nueva cuenta: una vez que haya determinado que su escuela está cubierta, tendrá que abrir una nueva cuenta, y agregar al estudiante y la cobertura
3. Agregar estudiantes y cobertura en la página MyAccount

Titulares de cuenta frecuentes

1. Inicio de sesión en MyAccount
2. Mantener datos del estudiante
3. Mantener la cobertura del seguro

Para información o asistencia sobre todos los seguros del estudiante, póngase en contacto con el departamento de servicio al cliente al (866) 409-5733.

Suscrito por Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

La póliza o certificado que afecta la cobertura y los servicios descritos en este aviso se proporciona exclusivamente en inglés. Así mismo, toda la documentación relacionada también se proporcionará exclusivamente en inglés. En caso de adquirir este producto, le recomendamos contactar a un traductor.

Nota: Las pólizas y certificados de aseguramiento se encuentran disponibles en español para los residentes de Puerto Rico, previa petición.

Mutual of Omaha | HSR Health Special Risk, Inc.