



**Fir Grove Elementary**

Roseburg, Oregon

**2024-2025**

**Fit for Learning, Fit for Life**

**1360 W. Harvard Ave**

**Roseburg, OR 97471**

**541-440-4085**

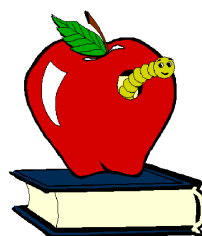


# Fir Grove Elementary

## 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 [ParentSquare](#) 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 [ParentSquare](#) 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	
Michelle Knee	Director of Human Resources	541-440-4007
Michelle Knee	Director of Student Services	541-440-4034
Cheryl Northam	Director of Business Services	541-440-4027

Board of Directors



- Rod Cotton
- Keith Cubic
- Steve Hammerson
- Anne Krimetz
- Michael Leone
- Andrea Miner
- Andrew Shirtcliff

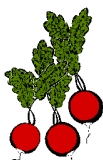
**FIR GROVE STAFF EXT. 2024-2025**

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

<u>PRINCIPAL</u>	Katrina Hanson	6302	<u>OFFICE MNGR</u>	Lisa Jarrett	6300
			<u>OFFICE ASST.</u>	Carole Whitehead	6301
<u>KINDER</u>	Amy Larman	6315	<u>LIBRARY</u>	Tracy Clements	6320
	Teri Moore	6312			
<u>FIRST</u>	Erika Patterson	6311	<u>CUSTODIANS</u>	Jen McIntosh	
	Jenny Parnell	6310		Lowneza Brown	
<u>SECOND</u>	Michelle Hammond	6326	<u>KITCHEN</u>	Dawn Cannon	6333
	Lindsay Ferguson	6327		Nadia Drygalov	6333
<u>THIRD</u>	Jeff Jackson	6314	<u>IA'S</u>	Pam Cobb	LRC
	Karami Miller	6313		Sonja El-Badry	LRC
<u>FOURTH</u>	Wesley Rea	6316		Christina Mills	LRC
	Valerie Titus	6317		Christina Wheeler	LRC
<u>FIFTH</u>	Courtney List	6318		Cassy Davis	Title
	Dennis Park	6319		Andrea Kellom	Title
<u>LRC</u>	Sherryl Bailey	6322	<u>IA'S – DLC</u>	Rhonda Carter	
<u>DLC</u>	Kristin Schriener	6308		Heather Clark	
<u>CNC</u>	Pam Schneider	6307		Alana Day	
<u>TITLE 1</u>	Jenny Eames	6328		Wanda Harris	
<u>CDS</u>	Corina VanBurger	6329		Hannah Humbert	
<u>PE</u>	Theresa Powell	TBD	<u>IA'S – CNC</u>	Audrey Rankin	
<u>MUSIC</u>	Taylor Siling	6323		Elliot Snyder	
<u>TOSA</u>	Jenny Carpenter	6325		Susie Wentworth	
<u>PSYCHOLOGIST</u>	TBD			Katrina Austin	
<u>ELD</u>	Karla Addington	6331		Sheila Clifton	
				Mia Cesena	
			<u>PAPERWORK MGR</u>	Tonya Phillips	6324
			<u>SKILLS TRAINER</u>	Terri Wetzel	6325
			<u>SPEECH</u>	Brandy Pickens	6334
				TBD	

## 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
<b>Lunch:</b>	<b>12:00-12:45</b>
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 97<sup>th</sup> percentile on specific assessments). All 2<sup>nd</sup> and 4<sup>th</sup> 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!**

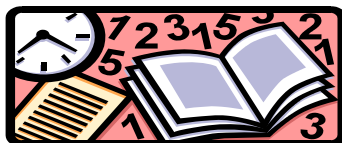
## Lost and Found/Leaving toys at home

- **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 Parent Square 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 call 911 and have them determine next steps.**
- 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 **2024-2025** school year are: **November 6 and 7; April 2nd and 3rd.**



## 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.

# CONSENT FOR DENTAL HYGIENE SERVICES



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

Please return by: \_\_\_\_\_

STUDENT INFORMATION																			
<b>Student's Name:</b> _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Last Name</span> <span>First Name</span> <span>Middle Initial</span> <span>Date of Birth</span> </div>																			
School Name: _____																			
<b>My student has:</b> <input type="checkbox"/> OHP <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Dentist _____																			
<b>Best phone number to reach you during the day:</b> _____ <b>Friend or family member's phone number to reach you in case you change your phone number:</b> _____																			
Address / City / State / ZIP: _____																			
<b>Grade / Teacher:</b> _____	<b>List medications currently taking:</b> _____ _____ <input type="checkbox"/> Iodine Allergy <input type="checkbox"/> Other Allergies (please list): _____ _____ <b>History of:</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Tobacco Use <input type="checkbox"/> Behavioral Considerations (please describe): _____ _____ Other (please describe): _____																		
<b>Gender:</b> <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/> Choose Not to Disclose																			
<b>The following services may be offered to the patient on an as-needed basis. Please mark YES or NO to indicate whether you consent to these services being provided on the patient listed above.</b>																			
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Screening (Teeth Check-up)</td> <td style="width: 10%; text-align: center;">YES</td> <td style="width: 20%; text-align: center;">NO</td> </tr> <tr> <td>Fluoride Coating</td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>Sealant</td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>Silver Fluoride</td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>Antiseptic for the Teeth (Iodine)</td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>Petroleum Jelly</td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table>	Screening (Teeth Check-up)	YES	NO	Fluoride Coating	YES	NO	Sealant	YES	NO	Silver Fluoride	YES	NO	Antiseptic for the Teeth (Iodine)	YES	NO	Petroleum Jelly	YES	NO	
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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 (jointly "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 insurance through a Coordinated Care Organization, the hygienist will notify the plan of the services received.

**Print Parent/Legal Guardian Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**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.

## Petroleum Jelly

Petroleum Jelly may be utilized for dry-chapped lips during treatment, as well as during the placement of sealants.



# CONSENTIMIENTO PARA LOS SERVICIOS DE HIGIENE DENTAL



Mercy Foundation y Advantage Dental quieren ayudar a mantener a su comunidad saludable y sin deterioro de los dientes. Los higienistas dentales estarán disponibles todo el año para ofrecer servicios dentales gratuitos. Estos servicios no reemplazan el cuidado dental regular de un dentista.

Favor de devolver para \_\_\_\_\_.

## INFORMACIÓN PARA EL ESTUDIANTE

Nombre del estudiante: _____																					
Apellido	Nombre	Inicial del segundo nombre	Fecha de nacimiento																		
Nombre de la escuela: _____																					
El estudiante tiene : <input type="checkbox"/> OHP <input type="checkbox"/> Privado <input type="checkbox"/> Ninguno <input type="checkbox"/> Dentista _____																					
Número de teléfono apropiado para comunicarse durante el día: _____																					
Número de teléfono de amigos o familiares para comunicarnos con usted en caso de que cambie su número de teléfono: _____																					
Dirección/ciudad/estado/código postal: _____																					
Grado / maestro: _____		Lista de medicamentos que toma actualmente: _____																			
Sexo: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Otro <input type="checkbox"/> Decide no revelarlo		<input type="checkbox"/> Alergia al yodo																			
<p><b>Se pueden ofrecer los siguientes servicios al paciente según sus necesidades. Marque <b>SÍ</b> o <b>NO</b> para indicar si da su consentimiento para que se presten estos servicios al paciente que se menciona anteriormente.</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Evaluación (examen de los dientes)</td> <td style="width: 10%; text-align: center;">SÍ</td> <td style="width: 10%; text-align: center;">NO</td> </tr> <tr> <td>Aplicación de flúor</td> <td style="text-align: center;">SÍ</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>Sellador</td> <td style="text-align: center;">SÍ</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>Fluoruro de plata</td> <td style="text-align: center;">SÍ</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>Antiséptico para los dientes (yodo)</td> <td style="text-align: center;">SÍ</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>Vaselina</td> <td style="text-align: center;">SÍ</td> <td style="text-align: center;">NO</td> </tr> </table>		Evaluación (examen de los dientes)	SÍ	NO	Aplicación de flúor	SÍ	NO	Sellador	SÍ	NO	Fluoruro de plata	SÍ	NO	Antiséptico para los dientes (yodo)	SÍ	NO	Vaselina	SÍ	NO	<input type="checkbox"/> Alergia a los mariscos (camarones, cangrejos, etc.)	
		Evaluación (examen de los dientes)	SÍ	NO																	
		Aplicación de flúor	SÍ	NO																	
		Sellador	SÍ	NO																	
		Fluoruro de plata	SÍ	NO																	
		Antiséptico para los dientes (yodo)	SÍ	NO																	
Vaselina	SÍ	NO																			
		<input type="checkbox"/> Otras alergias (enumérelas): _____																			
		Tiene antecedentes de:																			
		<input type="checkbox"/> Diabetes																			
		<input type="checkbox"/> Asma																			
		<input type="checkbox"/> Consumo de tabaco																			
		<input type="checkbox"/> Consideraciones de comportamiento (describa): _____																			
		Otro (describa): _____																			

Si tiene alguna pregunta o quiere obtener más información sobre los servicios prestados, llame a Mercy Foundation al 541-677-4818 o consulte la hoja informativa adjunta.

**Al firmar este consentimiento, usted indica que le informaron sobre los riesgos y beneficios del tratamiento, que le respondieron sus preguntas y que da su consentimiento al tratamiento mencionado anteriormente.**

Como padre, madre o tutor legal, estoy de acuerdo con todas las afirmaciones a continuación:

- Doy mi consentimiento para los servicios dentales firmados o mencionados anteriormente de Mercy Foundation, Advantage Dental Group, PC (en conjunto, "Advantage Dental") o uno de sus representantes.
- Los resultados de los servicios de higiene bucal, incluida la información de salud personal y la información de planificación, pueden compartirse entre Advantage Dental, el Programa de Extensión Healthy Kids de Mercy Foundation, el proveedor dental (higienista o dentista del paciente), el centro comunitario, cualquiera de las compañías de seguros enumeradas, el dentista registrado, cualquier Organización de Atención Coordinada correspondiente, o la Organización de Cuidado Dental registrada con fines de tratamiento, pago u operaciones de atención médica.
- Me entregaron una copia del "Aviso de prácticas de privacidad" y de la notificación de HIE (Intercambio de Información de Salud).
- Este consentimiento permanecerá vigente durante 12 meses a menos que se revoque por escrito o por teléfono llamando a un representante de Advantage Dental.
- Este consentimiento es válido en todos los lugares donde Mercy Foundation y Advantage Dental prestan sus servicios.
- Si tiene seguro dental a través de una organización de atención coordinada (CCO, por sus siglas en inglés), la higienista le avisara a su plan de los servicios recibidos.

Nombre en letra de imprenta del padre, la madre o el tutor legal: \_\_\_\_\_ Vínculo: \_\_\_\_\_

Firma del padre, la madre o el tutor 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

Una capa delgada temporal (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



Después 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.

## Vaselina

Podría utilizarse vaselina para labios secos y agrietados durante el tratamiento, además de durante la colocación de selladores



# Roseburg Public Schools

Office Use: Enrollment Date \_\_\_\_\_ Record # \_\_\_\_\_ Date Requested \_\_\_\_\_ Date Received \_\_\_\_\_

## STUDENT RECORDS REQUEST

Please **CIRCLE** the enrolling school:

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

**Medical Statement to Request Special Meals and/or Accommodations/Modifications**

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.

<b>School/Site Name:</b> _____	<b>Submit this form to:</b> School Office Manager or email to <a href="mailto:jabaker@roseburg.k12.or.us">jabaker@roseburg.k12.or.us</a>
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**Part I** To be completed by Parent/Guardian, Adult Participant, or

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.

<p>1. <b>Describe</b> the major life activity or major bodily function(s) affected by the participant’s physical or mental impairment that restricts the diet:</p> <p>_____</p> <p>_____</p>
<p>2. <b>Meal Accommodation Plan (Foods to omit or avoid):</b></p> <p>_____</p> <p>_____</p>
<p>3. <b>Foods to be substituted and recommended alternatives (include modification and accommodation):</b></p> <p>_____</p> <p>_____</p>
<p>Signature of State Licensed Health Care Professional:</p> <p style="text-align: center;">_____</p> <p style="text-align: center; display: flex; justify-content: space-around;"> <span>Printed Name</span> <span>Signature</span> <span>Date</span> </p>

**Part III** Use Only

Accommodation(s) Made: _____
Nutrition Services Coordinator Signature: _____ Date: _____

## Instructions for completing the Medical Statement to Request Special Meals and/or Accommodations/Modifications

1. **Organization Name:** Roseburg Public Schools
2. **School/Site Name:** Print the name of the school/site where meals will be served (e.g., ABC School, XYZ Child Care Center)
3. **Submit this form to:** School Office Manager or email to Nutrition Services Coordinator at [jabaker@roseburg.k12.or.us](mailto:jabaker@roseburg.k12.or.us)
4. **Part I:** This section can be completed by the **Parent/Guardian, Adult Participant, or Roseburg Public Schools**
  - 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 Accommodation 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 Nutrition Services Coordinator after Parts I and II are completed.
  - a. **Accommodations Made:** The Nutrition Services Coordinator will indicate what accommodations will be made for the requests made in Part II.
  - b. **Signature and Date:** The Nutrition Services Coordinator 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\*.

**\*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).

**Roseburg Public Schools District policy requires medical statements to be dated within the current school year which has been designated as July 1 to June 30 as medical conditions, allergies, and sensitives can change rapidly.**

**A new medical statement is required at the start of each new school year.**

## 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)*

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### 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 ✍ \_\_\_\_\_

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### 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 ✍ \_\_\_\_\_

## AUTHORIZATION FOR MEDICATION ADMINISTRATION

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)

<b>Medication:</b> _____	<b>Non-Prescription?:</b> Yes _____ No _____
<b>Dose</b> (strength/how much): _____	<b>Prescription Number:</b> _____
<b>Frequency</b> (how often): _____	<b>Pharmacy Name:</b> _____
<b>Time of day</b> for meds at school: _____	* Please allow my child to self-administer this medication.
<b>Route</b> (circle one): Mouth   Ear   Eye   Nose   Skin	<i>Requires self-medication agreement form to be signed by parent, school administrator, and if a prescription, consent of the physician. Yes: _____ No: _____</i>
<b>Start Date:</b> _____ <b>End Date:</b> _____	<b>ALL MEDICATION MUST BE IN ITS</b>
<b>Reason for medication:</b> _____	<b>NEWEST ORIGINAL CONTAINER WITH</b>
<b>Special Instructions:</b> _____	<b>AN ACCURATE LABEL.</b>

**\*\*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.*

**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

**DELEGATION OF PARENTAL/GUARDIAN POWERS**

I certify that I am the parent or legal guardian of:

\_\_\_\_\_  
(FULL NAME OF MINOR CHILD)

\_\_\_\_\_  
(DATE OF BIRTH)

\_\_\_\_\_  
(FULL NAME OF MINOR CHILD)

\_\_\_\_\_  
(DATE OF BIRTH)

\_\_\_\_\_  
(FULL NAME OF MINOR CHILD)

\_\_\_\_\_  
(DATE OF BIRTH)

(“minor child/ren”). I designate

\_\_\_\_\_  
(FULL NAME OF ATTORNEY-IN-FACT)

\_\_\_\_\_  
(STREET ADDRESS, CITY, STATE AND ZIP CODE OF ATTORNEY-IN-FACT)

\_\_\_\_\_  
(HOME PHONE OF ATTORNEY-IN-FACT)

\_\_\_\_\_  
(WORK PHONE OF ATTORNEY-IN-FACT)

as the undersigned’s attorney-in-fact with respect to the minor child/ren under ORS 109.056.

I delegate to the attorney-in-fact all of my power and authority regarding the care, custody and property of the minor child/ren, including but not limited to the right to enroll the minor child/ren in school, inspect and obtain copies of education records and other records concerning the minor child/ren, the right to attend school activities and other functions concerning the minor child/ren, and the right to give or withhold any consent or waiver with respect to school activities, medical and dental treatment, and any other activity, function or treatment that may concern the minor child/ren. **OR**

I delegate to the attorney-in-fact the following specific powers and responsibilities (write in):

This delegation does not include the power or authority of the attorney-in-fact to consent to the minor child/ren’s marriage or adoption.

LENGTH OF TIME (*select one*):

This power of attorney is effective for a period not to exceed six months, beginning \_\_\_\_\_, 20\_\_ , and ending \_\_\_\_\_, 20 . I reserve the right to revoke this authority at any time.

I am in the US Armed Forces and have been called to active duty. This power of attorney is effective through my active-duty period plus 30 days.

**TO BE SIGNED IN FRONT OF A NOTARY. DO NOT COMPLETE UNTIL YOU ARE WITH THE NOTARY.**

I agree to the delegation of parental/guardian powers for the minor child(ren) listed above as specified in this power of attorney.		I hereby accept my designation as attorney-in-fact for the minor child(ren) listed above as specified in this power of attorney.	
Parent/Legal Guardian Signature	Date	Parent/Legal Guardian Signature	Date
Notary Public		Notary Public	
State of	County of	State of	County of
Applicant Name		Applicant Name	
Signed before me on this date		Signed before me on this date	
By (notary’s signature)		By (notary’s signature)	





## **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:

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



# 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.

Child's Last Name <i>Apellido</i>	First <i>Primer Nombre</i>	Middle Initial <i>Segundo Nombre</i>	Birthdate <i>Fecha de Nacimiento</i>	Complete for all Up-to- date
Mailing Address <i>Dirección</i>	City <i>Ciudad</i>	State <i>Estado</i>	Zip Code <i>Codigo Postal</i>	
Parents' or Guardians' Names <i>Nombre de los padres o guardian</i>		Home Telephone Number <i>Número de Teléfono</i>		Non medical

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) <i>or</i> 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 _____

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

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

**Continued On Reverse Side**



# Oregon Certificate of Immunization Status, Page 2

## Oregon Health Authority, Immunization Program

Child's Last Name <i>Apellido</i>	First <i>Primer Nombre</i>	Middle Initial <i>Segundo Nombre</i>	Birthdate <i>Fecha de Nacimiento</i>
--------------------------------------	-------------------------------	-----------------------------------------	-----------------------------------------

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

Hepatitis B

Polio

Hepatitis A

Varicella

Hib

Measles/Mumps/Rubella

\_\_\_\_\_  
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 \_\_\_\_\_

# 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:

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.

Go to: [www.K12StudentInsurance.com](http://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.



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:

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.

Vaya a: [www.K12StudentInsurance.com](http://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.





**Voluntary Student Accident Insurance**  
[School Name- - - - -]  
Variable field- - - - -]

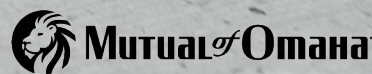
**Health Special Risk, Inc.**  
8400 Belleview Dr, Suite 150  
Plano, TX 75024

Phone: 866.409.5733, Ext. 5660  
Fax: 972.512.5819  
[www.healthspecialrisk.com](http://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.



[Policy Form Variable Field - - - - -]

# NATIONAL

2023-2024

## 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 80<sup>th</sup> 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**

<b>INPATIENT:</b>	<b>LOW OPTION</b>	<b>HIGH OPTION</b>
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)		
<b>OUTPATIENT:</b>		
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
<b>INPATIENT AND/OR OUTPATIENT:</b>		
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.





2023-2024
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:

Table with 3 columns: COVERAGE PLANS, LOW OPTION, HIGH OPTION. Rows include 24-Hour, 24-Hour Summer Only, At School, High School Football, Spring High School Football, Extended Dental. Includes a section for COMPANY USE ONLY with fields for Check # and Amount Rec'd, and a note to enclose a check for total amount payable to Health Special Risk.

\*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

**Health Special Risk, Inc.**  
8400 Belleview Dr, Suite 150  
Plano, TX 75024


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 Compañía de 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**

# A NIVEL NACIONAL

2023-2024

**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 por ciento 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 médico o el Gasto de un Seleccion Médico 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 médica, 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, bobsledding (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, pónicos, 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**

<b>PACIENTES HOSPITALIZADOS:</b>	<b>OPCIÓN – BAJA</b>	<b>OPCIÓN – ALTA</b>
<b>Alojamiento y Comida / Misceláneos de Hospital</b>	Tarifa de habitación semi - privada / máximo de \$150 por día	80% de la Tarifa Usual y Acostumbrada por Una Habitación Semi - privada
<b>Misceláneos de Hospital</b>	Hasta un máximo de \$600 por día	Hasta un máximo de \$1,200 por Día
<b>Enfermera Registrada o Graduada</b>	75% de los habituales	100% de los habituales
<b>Visitas del Médico No Quirúrgicas</b>	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)		
<b>PACIENTES AMBULATORIOS:</b>		
<b>Costo de Cirugía Ambulatoria-Cargos por Instalación Médica</b>	Hasta un Máximo de \$1,000	Hasta un Máximo de \$1,200
<b>Visitas del Médico No Quirúrgicas</b>	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)		
<b>Fisioterapia</b>	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
<b>Sala de Emergencia</b>	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)		
<b>Servicios de Rayos X - (Incluye cargos por lectura)</b>	Máximo de \$200	Máximo de \$600
<b>Cat Scan /MRI</b>	Máximo de \$300	Máximo de \$600
<b>Laboratorio</b>	Máximo de \$50	Máximo de \$300
<b>Inyecciones</b>	Hasta \$25, lesión	Hasta \$25, lesión
<b>Medicamentos con Receta</b>	Máximo de \$75	Máximo de \$200
<b>Aparatos y Accesorios Ortopédicos</b>	Máximo de \$75	Máximo de \$140
<b>PACIENTES HOSPITALIZADOS Y/O AMBULATORIOS:</b>		
<b>Honorarios del cirujano</b>	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)
<b>Anestesiista</b>	20% del gasto permitido para el cirujano	25% del gasto permitido para el cirujano
<b>Ambulancia</b>	Máximo de \$300	Máximo de \$800
<b>Consultor</b>	Máximo de \$200	Máximo de \$400
<b>Tratamiento del agotamiento por calor</b>	100% de los habituales	100% de los habituales
<b>Dental</b>	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)
<b>El reemplazo de anteojos, lentes de contacto y audífonos</b>	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 Primavera Escuela Secundaria	\$ 58.85	\$ 92.00
Dental Extendido	\$ 9.65	\$ 9.65



**2023-2024**  
**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: \_\_\_\_\_

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

\* 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](http://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**

## Formulario de certificación de examen dental

La ley estatal ahora exige que a los niños menores de 7 años se les haga un examen dental antes 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, llene esta sección, y firmela.
- 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 firmela. 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:

<b>Escuela Primaria Eastwood</b> 2550 SE Waldon St Roseburg, OR 97470 Teléfono: 541-440-4180 Fax: 541-441-4185	<b>Escuela Primaria Fir Grove</b> 1360 W Harvard Ave Roseburg OR 97471 Teléfono: 541-440-4085 Fax: 541-440-4086	<b>Escuela Primaria Fullerton IV</b> 2560 W Bradford Dr Roseburg OR 97471 Teléfono: 541-440-4081 Fax: 541-440-4082	<b>Escuela Primaria Green</b> 4498 SW Carnes Rd Roseburg OR 97471
<b>Escuela Primaria Hillcrest</b> 1610 NW Kline St Roseburg OR 97471 Teléfono: 541-440-4188 Fax: 541-440-4191	<b>Escuela Primaria Melrose</b> 2960 Melrose Rd Roseburg OR Teléfono: 541-440-4077 Fax: 541-440-4078	<b>Escuela Primaria Sunnyslope</b> 2230 SW Cannon Rd Roseburg OR Teléfono: 541-440-4192 Fax: 541-440-9485	<b>Distrito Escolar de Enseñanza Pública Roseburg</b> Escuela Primaria Winchester 217 Pioneer Way Winchester OR 97495
<b>Escuela Intermedia John C. Fremont</b> Atención: encargada de admisión 850 W Keady Ct Roseburg OR 97471 Teléfono: 541-440-5400 Fax: 541-440-4600	<b>Escuela Primaria Hillcrest</b> Atención: encargada de admisión 2153 NE Vine St. Roseburg OR 97470 Teléfono: 541-440-5300 Fax: 541-440-4100	<b>Escuela Primaria Hillcrest</b> 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):

- Expediente académico
- Expediente de conducta
- Certificado de salud/vacunas/nacimiento
- Expediente académico oficial/registros de progreso académico
- Grado en que se retiró/horario actual
- 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).
- Clave de su sistema de calificación y créditos
- Calificaciones de las Evaluaciones Equilibradas y Más Inteligentes y de las pruebas estatales (calificaciones generales y desglosadas/estándar).
- 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 bicicleta Parada 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  Ventrán 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 Niños y 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 excursiones escolares.

### 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 hijo en 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.

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Nombre del estudiante	Grado
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Firma del padre de familia o tutor	Fecha
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Nombre en letra de molde del padre de familia o tutor	Relación con el estudiante
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¡¡ LLENE Y DEVUELVA A LA ESCUELA EN LA QUE SE INSCRIBIRÁ - OBLIGATORIO PARA TODOS LOS ESTUDIANTES!!