OBJECTION TO PUBLICATION OF DIRECTORY INFORMATION

School Board Policy 4.13F---Objection to Publication of Directory Information

(Not to be filed if the parent/student has no objection)

I, the undersigned, being a parent of a student, or a student eighteen (18) years of age or older, hereby note my objection to the disclosure or publication by the Nemo Vista School District of directory information, as defined in School Board Policy No. 4.13 (Privacy of Students' Records), concerning the student named below. The district is required to continue to honor and signed opt-out form for any student no longer in attendance at the district.

I understand that the participation by the below-named student in any interscholastic activity, including athletics and school clubs, may make the publication of some directory information unavoidable, and the publication of such information in other forms, such as telephone directories, church directories, etc., is not within the control of the District.

I understand that this form must be filed with the office of the appropriate building Principal within ten (10) school days from the beginning of the current school year in order for the District to be bound by this objection. Failure to file this form within that time is a specific grant of permission to publish such information.

My objection is to the disclosure or publication of directory information to

Military recruiters _____

Public and school sources _____

Both military recruiters and public and school sources _____

____

Name of student (Printed)

____

Signature of parent (or student, if 18 or older)

____

Date form was filed (To be filled in by office personnel)

Relates to Board Policy 4.13 Handbook page 110

MEDICATION ADMINISTRATION RELEASE FORM

Student____ Date_____________________

Date of Birth___________________________________Grade________ Teacher______________________

Allergies____

TO BE COMPLETED BY PRIMARY CARE PROVIDER

Medication____

Dosage____Time To Be Administered___________________

Reason For Medication____

Possible Side Effects____

Special Instructions____

Physician / NP Signature____

Office Telephone____ Date_____________ _____________

TO BE COMPLETED BY PARENT

In Case of Emergency:

Hospital to be called_______________________________________Phone_____________________________

Parent____Phone______________________________

Alternate____Phone_____________________________

Health Care Provider_____________________________________Phone_____________________________

I request that you give medication to my child during the school day in accordance with the School District Medication Policy. I understand that in the absence of the school nurse, a designated staff member, instructed in the safe procedure for medication administration may give this medication.

I also, acknowledge that the District, its Board of Directors, and its employees shall be immune from any civil liablility for damages resulting from the administration of medications in accordance with this consent form.

Parent/Guardian Signature____Date______________________

Relates to Board Policy 4.35 Handbook page 82

SELF - MEDICATION ADMINISTRATION RELEASE FORM

Medication, including those for self-medication, must be properly labeled.

Student____ Date_____________________

Date of Birth___________________________________Grade________ Teacher______________________

Allergies____

TO BE COMPLETED BY PRIMARY CARE PROVIDER

Medication____

Dosage ____Time To Be Administered___________________

Reason for Medication____

Possible Side Effects____

Special Instructions____

I being the physician of _______________________________ has my permission to carry and administer his/her own medication.

Physician/NP Signature: ____

TO BE COMPLETED BY PARENT

In Case of Emergency:

Hospital to be called_____________________________________Phone_____________________________

Parent____Phone______________________________

Alternate____Phone_____________________________

Health Care Provider_____________________________________Phone_____________________________

I being the parent/guardian of _______________________________________ has my permission to carry his/her inhaler/ Auto-inject able epinephrine (epi-pen) while in school, or at an off- site sponsored activities.

No personnel of the Nemo Vista School District shall be liable for injury to a student caused by his/her use of the prescription inhaler or self-administration of medication.

Parent/Guardian Signature____Date_______________________

Relates to Board Policy 4.35 Handbook page 82

OBJECTION TO PHYSICAL EXAMINATIONS OR SCREENINGS

I, the undersigned, being a parent or guardian of a student, or a student eighteen (18) years of age or older, hereby note my objection to the physical examination or screening of the student named below.

Physical examination or screening being objected to:

_____ Vision test (PreK, K, 1st, 2nd, 4th, 6th, 8th & all transfer students are screened)

_____ Hearing test (PreK, K, 1st, 2nd, 4th, 6th, 8th, & all transfer students are screened)

_____ Scoliosis test (6th grade girls only & both boys and girls in 8th grades are screened)

_____ Height/Weight measurements (BMI) (K, 2nd, 4th, 6th, 8th, & 10th grades are measured)

_____ Other, please specify

Comments:
____
____
____

____
Name of student (Printed)

____
Signature of parent (or student, if 18 or older)

____
Date form was filed (To be filled in by office personnel)

Relates to Board Policy 4.41 Handbook page 87

REQUEST FOR RECONSIDERATION OF INSTRUCTIONAL SUPPLEMENT MATERIALS

Name: ____________________________________

Date submitted: Level one _____ level two _____ level three _____

Instructional material being contested:

____

____

____

____

____

Reason(s) for contesting the material (be specific):

____

____

____

____

____

Signature of receiving principal: ______________________________________

Signature of curriculum coordinator: __________________________________

Signature of superintendent: ____

Relates to Board Policy 5.6 Handbook page 136

REQUEST FOR RECONSIDERATION FORM
OF LIBRARY/MEDIA CENTER MATERIAL

Name: ____

Date submitted: ________________________________

Media Center material being contested:

____
____

Reason(s) for contesting the material (Be specific about why you believe the material does not meet the selection criteria listed in board policy 5.7—Selection of Library/Media Center Material):

____
____
____
____
____
____
____

What is your proposed resolution?

____
____
____

Signature of receiving principal: ____________________________________

Signature of superintendent (if appealed): ______________________________

Relates to Board Policy 5.7 Handbook page 137

PERMISSION TO DISPLAY PHOTO OF STUDENT ON WEB SITE

I hereby grant permission to the Nemo Vista School District to display the photograph of video clip of me/my student (if student is under the age of eighteen [18]) on the District's web site, including any page on the site, or in other District publications without further notice. I also grant the Nemo Vista School District the right to edit the photograph or video clip at its discretion.

The student's name may be used in conjunction with the photograph or video clip. It is understood, however, that once the photograph or video clip is displayed on a web site, the District has no control over how the photograph or video clip is used or misused by persons with computers accessing the District's web site.

____

Name of student (printed)

____

Signature of student (only necessary if student is over 18)

____

Signature of parent (required if student is under 18)

____

Date

Relates to Board Policy 5.20.1 Handbook Page 135

PERMISSION TO DISPLAY STUDENT INFORMATION ON WEB SITE
Board Policy 5.20.2

I hereby grant permission to the Nemo Vista School District to display my/my student's name (if student is under the age of eighteen (18)) in conjunction with my/my student's home address, email address, telephone number, and/or my parents' names.

It is understood, however, that once the information is displayed on a web site, the District has no control over how the information is used or misused by persons with computers accessing the District's web site.

I (we) agree to defend and hold harmless the members of the Nemo Vista School Board, the Nemo Vista School District, its officers, employees, agents, successors and assignees form and against any all claims and liabilities resulting from displaying my/my student's specified information.

____

Name of student (Printed)

____

Signature of student (only necessary if student is over 18)

____

Signature of parent (required if student is under 18)

____

Date

Relates to Board Policy 5.20.2 Handbook pg 133

SURVEY INFORMATION SHEET

I, the undersigned, begin a parent or guardian of a student, or a student eighteen (18) years of age or older, hereby note my objection or agreement to participation by the student named below in the following survey, analysis, or evaluation.

_____I choose not to have my student participate in the following survey, analysis, or evaluation.

_____ I choose to have my student participate in the following survey, analysis, or evaluation.

____

Name of student (Printed)

____

Signature of parent (or student, if 18 or older)

____

Date form was filed (To be filled in by office personnel)

This is "only" an example. If a survey is to be administrated, this form will be sent home with a description of the survey.

Relates to Board Policy 5.24 Handbook Page 109

4.35 – GLUCAGON ADMINISTRATION AND CARRY CONSENT FORM

Student's Name: ____

The student has developed Section 504 Plan acknowledging that my child has been diagnosed from Type I diabetes. The 504 Plan authorizes the school nurse or, in the absence of the nurse, trained volunteer district personnel, to administer Glucagon in an emergency situation to my child.

I hereby authorize the school nurse or, in the absence of the nurse, trained volunteer district personnel designagted as care providers, to administer Glucagon to my child in an emergency situation. Glucagon shall be supplied to the school nurse by the student's parent or guardian and shall be in the original container.

I acknowledge that the District, its Board of Directors, its employees, its employees, or an agent of the District including a healthcare professional who trained volunteer school personnel designated as care providers shall not be liable for any damages resulting from his/her actions or inactions in the administration of Glucagon in accordance with this consent form and the 504 Plan.

Parent or legal guardian signature: ____

Date: ______________________________

Volunteer signature: ____

Date: ______________________________

Date Adopted: June 2012

Relates to Board Policy 4.35 Handbook Page 82

4.56.2F---HOME SCHOOLED STUDENTS' LETTER OF INTENT TO PARTICIPATE IN AN EXTRACURRICULAR ACTIVITY AT RESIDENT DISTRICT

Student's Name (Please Print): ____

Parent or Guardian's Resident Address
Street: ____

Student's date of birth: ___/___/___ Last grade level the student completed: __________

Student has demonstrated academic eligibility by obtaining a verifiable minimum test score of the 30th percentile or better in the previous 12 months of the Stanford Achievement Test Series, Tenth Edition, or another nationally Recognized norm-referenced test approved by the State Board of Education.

Name of test, Date taken, and score achieved : ____

Extracurricular activity(ies) the student requests to participate in: _________________________________

____

Course(s) the student requests to take at the school: ____

Proof of identity: ____________

Date Submitted: ___/___/___

Parent's Signature: ____

Date Adopted: June 2017

Relates to School Board Policy 4.56.2 Student Handbook pg 94

4.56.2F2---HOME SCHOOLED STUDENTS' LETTER OF INTENT TO PARTICIPATE IN AN EXTRACURRICULAR ACTIVITY AT NON-RESIDENT DISTRICT

Student's Name (Please Print): ____

Parent or Guardian's Resident Address:

Street: ____

City: _____________________________State: _______ Zip Code: ___________

Student's date of birth: __/__/__ Last grade level the student completed: _____

Student has demonstrated academic eligibility by obtaining a verifiable minimum test score of the 30th percentile or better in the previous 12 months on the Stanford Achievement Test Series, Tenth Edition, or another nationally recognized norm-referenced test approved by the State Board of Education.

Name of test, Date taken, and score achieved: ____

Extracurricular activity(ies) the student requests to participate in: ____

Course(s) the student requests to take at the school: ____

Proof of identity: ________________

Date Submitted: _________________

Parent's Signature: ____

As the superintendent of the above student's resident district, I agree that the above student may participate in extracurricular activities at Nemo Vista School District.

Resident Superintendent's Signature: ____

As the superintendent of the Nemo Vista School District, where the above student desires to participate in extracurricular activities, I agree to allow the student to participate in extracurricular activities at the Nemo Vista School District.

Non-resident Superintendent's Signature: _______________________________________

Date Adopted: June 2017

Relates to School Board Policy 4.56.2 Student Handbook pg 94

School Meal

CERTIFICATION OF DISABILITY

For Special Dietary Needs

Part I (to be completed by the school)

Student's Name: ____ **Age:** ________

School Name and Address: ____
____

School District: ____

School Principal: ____**Phone:** ____________________________

Teacher: ___________________________________ **Food Service Manager:** ___________________________

Other Team Members: ____

Part II (to be completed by a licensed physician)

A student with a disability as defined by the Federal regulations for child nutrition programs is one who has a "physical, mental impairment which substantially limits one or more major life activities such as, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."

Patient's Name: ____

Diagnosis: ____
____
____

Describe the patient's disability and check the major life activities affected by the disability:
____

_____ **Caring for one's self** _____ **seeing** _____ **breathing**

_____ **performing manual tasks** _____**hearing** _____**learning**

_____**walking** _____**speaking** _____**working**

_____**other:** ____

Does the disability restrict the individual's diet? ☐ **Yes** ☐ **No**

If yes, list the food(s) to be omitted, substituted, requiring texture changes, or caloric modification.
____
____
____
____

____________________________ ____________________________________

Date **Signature**

Part III (optional to be completed when appropriate by a licensed Registered Dietitian (RD), Nurse (RN), or other health care team member).

Instructions given parents regarding child's nutritional needs:

____
____
____

List the nutrition materials given parents for school use:

____
____
____
____

Describe the special feeding device(s) needed:

____
____
____

Describe the feeding assistance needed:

____
____
____

Specify special dining area requirements:

____
____
____

Specify any special food preparation and storage needs:
(i.e., tube feeding blended in an approved food preparation area with attention paid to maintaining the product below 45 and above 140 degrees.)

____
____
____
____
____
____

____
Signature of RD, RN, and/or Health Care Team Member

____
Facility of Agency

____
Phone Number

____
Date

____
Mailing Address

Relates to School Board Policy 4.50 Student Handbook pg 85