

HOME COPY

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INSTRUCTIONS: PLEASE READ THE FOLLOWING DOCUMENT. KEEP THE HOME COPY FOR YOUR RECORDS. SIGN THE OFFICE COPY AND RETURN IT TO SCHOOL AS SOON AS POSSIBLE.

Parents, Students, and District Employees: The purpose of this agreement is to outline the rules of using computers in the Eldon R-1 Schools. Since students using computers will also be using the local and wide area network, which includes connecting to the Internet, the rules must be understood by all parents, students, and district employees. Your signature on the attached contract is legally binding and indicates that you have read the terms and conditions carefully and understand their significance.

ELDON R-1 SCHOOL DISTRICT NETWORK AND INTERNET ACCESS ACCEPTABLE USE POLICY

The Eldon R-1 School District is responsible for securing its network and computing systems in a responsible and economically feasible degree against unauthorized access and/or abuse, while making them accessible for authorized and legitimate users. This responsibility includes informing users of expected standards of conduct and the punitive measures for not adhering to them. Any attempt to violate the provisions of this policy will result in cancellation of user privileges and disciplinary action.

A user is required to use network resources in an efficient, ethical, and legal manner. The use of your access must be in support of education/research and consistent with the educational objectives of the Eldon R-1 District. Activities that are acceptable include classroom activities, career development, and research. Students may not use the resources of the Eldon R-1 School District for entertainment purposes.

In compliance with the Children's Internet Protection Act (CIPA), the district utilizes blocking software and a filtering system to guard against inappropriate access.

Network Etiquette: Students are expected to abide by the generally accepted rules of network etiquette. Etiquette rules include, but are not limited to, the following:

- Students must be polite and use appropriate language. Students should not use abusive language and vulgarities.
- Students must not reveal their personal identifying information (name, address, phone number, social security number, credit card number) or those of others.
- The network must not be used in such a way that would cause disruption of the use of the network by other users.

Guidelines and Conditions:

Privileges: The use of MORENet/Internet access is a privilege, not a right, and inappropriate use will result in a cancellation of these privileges. The Technology Coordinator may deny access at any time as required. The administrators, faculty and staff may request the Technology Coordinator to deny, revoke, or suspend specific user access.

Acceptable Use: The use of your access must be in support of education/research and be consistent with the educational objectives of the Eldon R-1 District.

Unacceptable Use & Network Security: The activities listed below are prohibited:

- Violation of laws, local, state, federal and/or international, including criminal, copyright, privacy, defamation and obscenity laws. *The school district will render all reasonable assistance to local, state, or federal officials for the investigation and prosecution of persons using district technology in violation of any law.*
- Use of district technology for soliciting, advertising, fundraising, commercial purposes or for financial gain, unless authorized by the district.
- Deleting, examining, copying, or modifying of files and/or data belonging to other users without their prior consent.
- Using any computer access accounts other than those assigned to the individual. This includes misrepresenting self through the use of another person's ID.
- Accessing, viewing, or disseminating information using district resources, including e-mail or Internet access, that is pornographic, obscene, child pornography, harmful to minors, obscene to minors, libelous, pervasively indecent or vulgar, or advertising any product or service not permitted to minors.
- Introduction of computer "viruses," "hacking" tools or other disruptive/destructive programs into a school or district computer, network, or any external networks.
- Deliberately tampering with a computer system (e.g., disconnecting and/or switching cables or changing computer settings).
- Giving personal information, such as complete name, phone number, address, social security number, credit card, or identifiable photo without permission from teacher and parent or guardian.
- Using online communication tools/forums (e.g., chat rooms, blogs, instant messaging, personal e-mail, pod casts, and Web pages) except for designated classroom activities.
- Failing to care for computer equipment. Objects should not be placed on monitors, computers, or keyboards. *Food and beverage should never be used in the vicinity of computers or peripherals.*

Consistency with Other School Policies: Use of the school district computer system and use of the Internet shall be consistent with school district policies and the mission of the school district.

Limitation of School District Liability: The school district system is provided on an "as is, as available" basis. The school district will not be responsible for financial obligations arising through unauthorized use of the school district system or the Internet. Users who subscribe to online services that charge fees are solely responsible for all charges incurred.

Vandalism: Vandalism will result in cancellation of privileges. Vandalism is defined as any malicious attempt to harm or destroy data or another user, damage to equipment or software, and interference with the MORENet or local network services.

Privacy: Administrators may review communications at any time to maintain system integrity. Users should not expect that files stored on district servers will be private.

Internet Use Agreement: The proper use of the Internet and the educational value to be gained is the joint responsibility of the students, parents, and employees of the school district. Staff members and all students must sign an agreement.

OFFICE COPY

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Eldon R-I Schools
Network and Internet Access Acceptable Use Agreement

By signing this document, the student and parent indicate that they have read and agree to abide by the rules stated in the Network and Internet Acceptable Use Policy. This document will be kept at the school for the duration of the student's attendance within the Eldon R-I Schools.

Student's Agreement

I have read the Network and Internet Access Acceptable Use Policy and agree to follow the rules and regulations it contains. I further understand that any violation of the guidelines may result in my computer use and Internet privileges being restricted, revoked, or suspended and may result in school disciplinary action.

Print Name

Signature

Date

Parent's/Guardian's Agreement

As the parent or guardian of this student, I have read the Acceptable Use Policy. I understand that Internet access at school is provided for educational purposes only. I understand that employees of the school system will make every reasonable effort to restrict access to all controversial material on the Internet, but I will not hold them responsible for materials my son or daughter acquires or sees as a result of the use of the Internet from school facilities. I give my permission to Eldon R-I Schools to allow the student above to use the Internet on computers at the school. I understand that violation of this agreement may result in computer privileges being restricted, revoked, or suspended and may result in school disciplinary action.

Signature of Parent or Guardian

Date

COMC

Central Ozarks
Medical Center
Medical • Behavioral • Dental

Dear Parents/Guardians,

The Eldon R-I School District has partnered with Central Ozarks Medical Center to offer medical services through a school-based health clinic to all of our students. This clinic is housed in the Tornado Shelter between South Elementary and Upper Elementary, but most services will be provided in the nurse's office at each school. Jillynn Hull, Family Nurse Practitioner, will provide these services under the supervision of COMC's pediatrician, Dr. Kristin Theobald-Hazel & family practice physician, Dr. Jamie Thomas. Jillynn can provide a complete range of medical services for your child, from urgent care when they become sick at school to monitoring chronic conditions, such as asthma. Additionally, Jillynn is able to write prescriptions. All of these services will be offered to our students at **no cost to the family!**

Should your child become sick at school, they will follow normal procedures and see our school nurses. If the school nurse feels that further treatment is necessary, you will be contacted and upon your approval, the nurse will contact Jillynn. Our hope is that this provides our students with fast, consistent and economical access to health care so they can focus on what's important... growing in their education!

COMC is a local non-profit organization that has worked to meet the health care needs of our community and the surrounding area since 1979. This program will provide any pre-registered child an opportunity to receive medical services at school during normal school hours.

There will never be any treatment provided to your child without your consent. Should your child need to be seen by Jillynn, you (or another person you have identified on the registration forms) will be called prior to any care occurring, and you always have the option of being present during care. You will also receive a summary of any care your child receives, and any prescriptions or other referrals your child needs. If you indicate on the form the name of your child's medical provider, we will provide records of any visit your child has at the school to that medical provider. We will bill your child's insurance, if any, for the services they receive, but any remaining balance **WILL NOT** be billed to the parents/guardians.

We look forward to working with you to provide the best possible medical health services for your child. The COMC clinic will also be open during the summer months. Office hours are Monday-Friday 8am - 4pm. To schedule an appointment for your child with Jillynn, please call the school-based health clinic at 573-392-8056.



Central Ozarks
Medical Center

Medical • Behavioral • Dental

Patient Registration Form for Medical and/or Dental Services

Student name (Please Print): _____

Parent/Guardian Name (Please Print): _____

Mailing Address: _____

Sex: _____ Male _____ Female Birth Date: _____ Grade in School: _____

Home Phone: _____ Cell Phone: _____

Email: _____ @ _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Please indicate if you would like your child to receive on a twice-yearly basis
Please mark any services you **DO NOT** want your child to receive (note, if DENTAL EXAM is marked, no other
services can be performed):

_____ Oral Hygiene Instruction and Education

_____ Dental Exam

_____ Fluoride Treatment

_____ Cleaning

_____ Sealants

_____ X-Rays

Responsible/Insured Party Information:

This section must be completed. If uninsured, please mark the appropriate box below.

Child is covered by Medicaid: Yes No Medicaid #: _____

Uninsured

If other Medical Insurance (not Medicaid):

Name of Insurance: _____

Policy Number: _____ Group Number: _____

Insurance Billing Address (back of card): _____

Name of Policy Holder: _____ Relationship to patient: _____

Policy Holder Date of Birth: _____ Employer: _____

If other Dental Insurance (Not Medicaid):

Name of Dental Insurance: _____

Dental Policy Number: _____ Dental Group Number: _____

Dental Claims Address (back of card): _____

Name of Policy Holder: _____ Relationship to patient: _____

Policy Holder Date of Birth: _____ Employer: _____

Social Security Number of Policy Holder

(if you prefer a phone call to provide this information please write "call": _____)

I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

Signature: _____ Date: _____

If not the patient or parent of patient; please note if you are the Guardian or Power of Attorney and supply documentation

Consent for Treatment for Medical and/or Dental Services

I, _____, consent for treatment of _____
Printed Name of Parent/Guardian Printed Name of Student

I attest that I have legal responsibility for this patient and the legal right to direct the medical/dental treatment of this patient. This consent allows for treatment today and all future appointments. This record may be given to other providers within Central Ozarks Medical Center to treat this minor as needed.

I understand that my child will be receiving services at school during the school day, and that I will be kept informed of when my child receives services and will be updated on their progress.

Signature of Parent/Guardian

Date

HIPAA Release

I authorize the additional individuals listed below to provide consent for treatment and to receive health information related to my child's treatment.

Authorized Individual(s) and Phone Number(s) _____

I give Central Ozarks Medical Center (COMC) consent for treatment of my child for health care services. I understand that services are available without discrimination prohibited by federal and state law. I understand that no treatment will be given without my knowledge or consent unless it is an emergency.

- I understand that the information in my child's health record is confidential and will not be released to any unauthorized person or agency without my consent.
- I authorize COMC to only disclose any portion of my child's health record to school personnel only as it relates to my child's academic success, including scheduling treatment and confirmation that my child is receiving services.
- I authorize COMC to have access to my child's school records only to assist in providing necessary care to my child.

Health History

Student Name: _____ Date of Birth: _____

Please list any health concerns: _____

Is your child under a physician's care now? ☐ Yes ☐ No

If yes, please list physician's name and name of the medical clinic: _____

Is your child taking any over-the-counter or prescription medications or vitamins? ☐ Yes ☐ No

If yes, please list: _____

Preferred Pharmacy: _____

Has your child ever been to the hospital due to serious illness, injury, or surgery (Please provide details)?

Is your child allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Nut Allergy ☐ Milk Protein
☐ Tylenol ☐ Ibuprofen/NSAIDS ☐ Other? _____

Is there any additional information that you feel is important or would help in the treatment of your child?

Family Medical History

Has your child ever had any of the following?	Yes	No	Comments			
ADHD						
Asthma			Mild	Moderate	Severe	Exercise Induced
Autism						
Blood Disorders (Anemia, Hemophilia, Sickle Cell Disease)						
Cancer						
Cystic Fibrosis or Respiratory Disease						
Endocrine Disease (Diabetes, Thyroid, Glandular)						
Genetic Disorder/Syndrome (please describe)						
Heart Disease (murmur, surgery, previous endocarditis, congenital abnormality)						
Immunocompromise						
Kidney Disease						
Liver Disease (Hepatitis)						
Mental or emotional problems, or developmental delays						
Neurological Disease (seizures)						

STD or HIV			
Severe Headaches			
Sight, hearing, or speech disorder			
Skin, bone, muscle or joint disease			
Other:			

Consent and Acknowledgement of Receipt of Privacy Practices

I attest that to the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health and unlawful. It is my responsibility to inform the medical/dental office of any changes related to the information in this packet.

We are committed to protecting your personal health information in compliance with the law. Our Notice of Privacy Practices is attached (final page of packet). We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy.

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature of Parent/Guardian

Date

Notice of Privacy Practices

Please tear this page off and retain for your records

This notice describes how medical information about you can be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions, please contact our Privacy Officer at phone number (573) 765-5131 or cmcelyea@centralozarks.org.

Who will follow this notice?

The list below tells you who will follow the outlined practice for keeping your medical record private.

All Central Ozarks Medical Center Medical and Dental Clinics (COMC). Any COMC health care professional that treats you at any of our locations. All COMC employees, temporary or contract staff, students and volunteers.

What is this Notice?

We are required by law to maintain the privacy of your protected health information. We are also required by law to give you this notice of our legal duties and privacy practices regarding your health information. We are required to notify you if there is a breach of your unsecured protected health information. We are required to follow the terms of the current Notice of Privacy Practices.

We may use and disclose your health information for:

Treatment: We may use and disclose health information for your medical treatment and services. **Payment:** We may use and disclose health information to bill for and receive payment for the services provided to you. **Health Care Operations:** We may use and disclose health information for purposes of health care operations. **Appointment Reminders:** To remind you that you have an appointment scheduled with us. **Treatment Alternatives:** To inform you of treatment options available to you. **As required by Law:** When required to do so by applicable law. **To prevent a Serious Threat to Health or Safety:** To prevent a serious threat to your health and safety or the health and safety of others. **Individuals Involved in your Care:** Unless you object, to friends, family members or others involved in your medical care or who may be helping pay for your care. **Organ and Tissue Donation:** Organ or tissue donation to organizations that handle organ procurement and transplant. **Decedents:** Health records for patients deceased 50 or more years are no longer considered Protected Health Information. **Genetic Information:** Genetic Information is considered Protected Health Information, which may be disclosed with authorization but cannot be used by health plans for underwriting purposes. **Military and Veterans:** If you are a member of the armed forces, as required by military command authority. **Worker's Compensation:** For worker's compensation purposes or similar programs providing benefits for work related injury or illness. **Public Health Activities:** For public health activities such as preventing or control of disease, reporting births and deaths, and reporting child abuse and neglect. **Health Oversight Activities:** To governmental agencies and boards as authorized by law such as licensing and compliance purposes. **Breach Notification:** Uses or disclosures of PHI that are not permissible are now presumed to be a Breach, unless it can be demonstrated a "low probability" exists that your PHI has been compromised or that an exception applies. **Disaster Relief:** Unless you object, to disaster relief organizations to coordinate your care or notify family and friends of your location or condition following a disaster. **Lawsuits and Disputes:** In response to a warrant, court order, or other lawful process. **Law Enforcement:** Pursuant to process and as otherwise required by law. **Coroners, Medical Examiners, Funeral Directors:** As necessary to determine the cause of death or to perform their duties. **National Security and Intelligence Activities:** To authorized federal officials for intelligence and other national security activities as authorized by law. **Protective Services for the President and Others:** To federal officials to provide protection to the President and other authorized persons, or conduct special investigations. **Inmates or Individuals in Custody:** If you are an inmate or in the custody of law enforcement, we may disclose to the correctional institution or law enforcement official as necessary to provide you with health care, to protect the health and safety of you and others, or for the safety and security of the correctional institution. **Research Studies and Clinical Trials:** Authorizations may be combined in the research context subject to certain requirements, and authorizations for future research are also permitted. **Business Associates:** Business Associates are directly liable for violations of the HIPAA/HITECH Act. Subcontractors of a business associate that create, receive, maintain or transmit PHI on behalf of the business associate are likewise HIPAA business associates, and subject to the same requirements that the first business associate is subject to. **Fundraising:** For raising funds. You may opt out of receiving fundraising communications at any time. **Other disclosures:** With certain exceptions, we are not allowed to use or disclose psychotherapy notes without your authorization. We are also not allowed to use or disclose your health information for marketing purposes or sell your health information without your authorization. Other uses and disclosures of your health information not described in this Notice of Privacy Practices or applicable laws will require your written authorization. If you choose to permit us to use or disclose your health information, you can revoke that authorization by informing us of your decision in writing. If you revoke your authorization, we will no longer use or disclose your health information as set forth in the authorization. However, any use or disclosure of your health information made in reliance on your authorization before it was revoked, will not be affected by the revocation.

Your rights regarding your health information: In most cases, you may make a written request to look at, or get a copy of your health information. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you have the right to have that denial reviewed by a licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of that review. **If your health information is maintained in electronic format, you have the right to request an electronic copy of your health information.** If your health information is not readily producible in the format you request, it will be provided either in our standard electronic format or as a paper document. We may charge you a reasonable cost based fee for the labor associated with transmitting electronic health information. If you feel your health information is incorrect or incomplete, **you have the right to request that we amend your information.** You must submit a written request providing your reason for requesting the amendment to the Privacy Officer. Your request to amend your health information may be denied if it was not created by us; if it is not part of the information maintained by us; or if we determine that the information is correct. You may submit a written appeal if you disagree. Your request for amendment will be included as a part of your health information. **You have the right to receive a list of certain disclosures we made of your health information,** for a period of time up to six years prior to the date of your request. The first list you request in a 12-month period is free. If you make more requests during that time, you may be charged our cost to produce the list. We will tell you about the cost before you are charged. **You have the right to a paper copy of this notice.** You may ask us to give you a copy of this notice at any time. **You have the right to request that your health information be given to you in a confidential manner.** You have the right to request that we communicate with you in a certain way or at a certain location, such as by mail or at your workplace. Any such request must be made in writing to the Privacy Officer. We will accommodate reasonable requests. **You have a right to ask that we not disclose your health information to your health plan if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law.** Such restricted disclosure must pertain solely to a healthcare item or service for which you, or someone on your behalf, have paid us in full. You may request, in writing, that we not use or disclose your health information for treatment, payment or healthcare operations; or to persons involved in your care; when required by law; or in an emergency. All written requests or appeals should be submitted to our Compliance Office listed at the end of this notice. We are not required to agree with the requested restrictions. **You have the right to be notified if there is an unauthorized use or disclosure of your unsecured protected health information unless we determine that there is a low probability that your information has been compromised.**

Complaints:

If you believe that your privacy rights may have been violated, you may contact our Privacy Officer, Courtney McElyea, at 573-765-5131 or by email at cmcelyea@centralozarks.org. You may write us at Central Ozarks Medical Center Attn: Courtney McElyea PO Box 777, Richland, MO 65556. You may also contact Missouri Department of Health, Bureau of Health Facility Regulation: 1-573-751-6303 and/or the State Attorney General's Office Consumer Hot Line: 1-800-392-8222. You may file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights at:

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html> The Office of Corporate Compliance can provide the mailing address. We will not retaliate against you for filing a complaint. If we change our policies regarding our use and/or disclosure of your protected health information, we will change our Notice of Privacy Practices and make the revised notice available to you on our website and our practice locations. You may access our website at <http://www.centralozarks.org>. You may also request a paper copy of the current Notice of Privacy Practices at any time.

2019-2020 Missouri School Immunization Requirements

- All students must present documentation of up-to-date immunization status, including month, day, and year of each immunization before attending school.
- The Advisory Committee on Immunization Practices (ACIP) allows a 4-day grace period. Students in all grade levels may receive immunizations up to four days before the due date.
- Required immunizations should be administered according to the current Advisory Committee on Immunization Practices Schedule, including all spacing, (<http://www.cdc.gov/vaccines/schedules/index.html>).
- To remain in school, students "in progress" must have an Immunization In Progress form (Imm.P.14) on file. In progress means that a child has begun the vaccine series and has an appointment for the next dose. This appointment must be kept and an updated record provided to the school. If the appointment is not kept, the child is no longer in progress and is noncompliant. (i.e., Hep B vaccine series was started but the child is not yet eligible to receive the next dose in the series.)
- Religious (Imm.P.11A) and Medical (Imm.P.12) exemptions are allowed. The appropriate exemption card must be on file. Unimmunized children are subject to exclusion from school when outbreaks of vaccine-preventable diseases occur.

Vaccines Required for School Attendance	Dose Required by Grade												
	K	1	2	3	4	5	6	7	8	9	10	11	12
DTaP/DTP/DT ¹	4+	4+	4+	4+	4+	4+	4+	4+	4+	4+	4+	4+	4+
Tdap ²									1	1	1	1	1
MCV ³ (Meningococcal Conjugate)									1	1	1	1	2
IPV (Polio) ⁴	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
MMR ⁵	2	2	2	2	2	2	2	2	2	2	2	2	2
Hepatitis B ⁶	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Varicella ⁷	2	2	2	2	2	2	2	2	2	2	1	1	1

1. Last dose on or after the fourth birthday and the last dose of pediatric pertussis before the seventh birthday.
Maximum needed: six doses.

2. 8-12 Grades: Tdap, which contains pertussis vaccine, is required.

3. Grade 8-11: One dose of MCV is required. Dose must be given after 10 years of age.

Grade 12: Two doses of MCV are required unless the first dose was administered to a student who was 16 years of age or older, in which case only one dose is required. At least one dose must be given after 16 years of age.

4. Kindergarten-9 Grade: Last dose must be administered on or after the fourth birthday. The interval between the next-to-last and last dose should be at least six months.

10-12 Grades: Last dose on or after the fourth birthday. Any combination of four doses of IPV and OPV constitutes a complete series. **Maximum needed:** four doses.

5. First dose must be given on or after twelve months of age.

6. There must be at least four weeks between dose one and two; at least 8 weeks between dose two and three; at least 16 weeks between doses one and three and final dose must be given no earlier than 24 weeks of age.

7. First dose must be given on or after twelve months of age.

Kindergarten-9 Grade: As satisfactory evidence of disease, a licensed health care provider may sign and place on file with the school a written statement documenting the month and year of previous varicella (chickenpox) disease.

10-12 Grades: As satisfactory evidence of disease, a parent/guardian or MD or DO may sign and place on file with the school a written statement documenting the month and year of previous varicella (chickenpox) disease.



Eldon R-1 School District – Health Services
Student Health Information
2019-2020

Please fill out and return to the school nurse. This form must be filled out yearly.

Student Name _____	Birth Date _____	Grade _____	
HEALTH CONDITION (Check all that apply)	YES	NO	DIAGNOSIS DATE / TREATMENT and /or MEDICATION (s)
ADD _____ ADHD _____			
Autism _____ Asperger's _____			
Asthma Carries inhaler Y ___ N ___ Type: _____ If carries an inhaler, a medication authorization (Dr. Signature) needs to be on file. Asthma Triggers: _____			
Bone/Joint problem			
Bowel, bladder or kidney problems (specify which one) _____			
Diabetes			
Chronic Earaches/Infections –Tubes present R ___ L ___			
Chronic Headaches _____ Migraines _____			
Hearing Loss— Ear (s) R ___ L ___ Aid(s) _____			
Heart Condition: _____			
Irritable Bowel Syndrome			
Menstrual Cramps: Frequent _____ and/or Severe _____			
Mental Health Concerns			
Nosebleed: Frequent _____ and/or Severe _____			
Seizure Disorder Date of Last Seizure: _____			
Skin Problems --Concern: _____			
Traumatic Brain Injury/ Head injury			
Vision Concerns- Wears Glasses Y ___ N ___			
Contacts Y ___ N ___ all the time _____			
Reading: _____ Distance: _____			

Allergic to: _____ (food, medications, latex insects)

Comments about any of the above checked items or **any other concerns:** _____

Does your child require long-term medications OR special diet restrictions **at school?** Y ___ N ___ Meds _____ and/or Diet _____

Specify meds or type of diet: _____

If checked yes, a **“Medication Authorization” and/or Special Dietary Needs” form(s) must on file. Forms available from Nurse’s Office**

Please list all medications your child is taking at home and at school. _____

YES _____ I GIVE my permission for the School Nurse or designated personnel to give acetaminophen or ibuprofen *without*
Initial _____ contacting a parent/guardian

NO _____ I DO NOT give my permission for the School Nurse or designated personnel to give acetaminophen or ibuprofen
Initial _____ *without* contacting a parent/guardian.

IMPORTANT:

If your child will be taking medication at school, please obtain the appropriate forms in the nurse's office.

All medication must come in the original containers with the students name on it. All prescriptions must but have a current date on the bottle.
Medications sent to school must be accompanied by a signed and dated note from the parent/guardian requesting the medication to be given.

Your child’s health history is important for us to provide the best care at school. The Eldon R-1 School District provides screenings for vision, hearing, height, weight, blood pressure, and scoliosis. It is the parent/guardian(s) responsibility to notify the school of any new or existing health conditions or change in telephone numbers. The disclosure of confidential health information within the school is limited to information to serve the student’s health and education interests. Your signature gives permission for the nurse and/or designee to perform necessary screenings and to inform the school staff of procedures to protect your child at school and, if required, develop emergency plans. In addition, your signature authorizes the school nurse or designee to screen, examine, treat and direct the care for your child in the event of illness or injury and to use the following over-the-counter medications as directed, unless allergy specified: Benadryl, cough drops, Tums, hydrocortisone cream, antibiotic cream, calamine, sunscreen, Orajel, Lip Balm and topical anti-sting treatments and generic substitutes

Parent/Guardian Signature

Date

BUS TRANSPORTATION REQUEST FORM

1. All requests must be completed and given to the student's Building Official for review prior to their approval.
THREE SCHOOL DAYS NOTICE IS REQUIRED BEFORE A REQUEST MAY BE GRANTED.
2. Final approval of request must be made by the Transportation Department prior to student being placed on a transfer bus to insure that all parties involved (parent/guardian, teacher, building official, Transportation Department and bus driver) are informed and the student's safe transportation is assured.
3. Transfer students must present a bus pass to the driver, given to them by the Principal's Office, to ride their new bus to their new location. The transfer stop should be written on the bus pass given to the new driver.

REASON FOR REQUEST: New Student _____ Address Change _____ Child Care _____
Parental Custody _____ Other _____

South School _____ Upper Elementary _____ Middle School _____ High School _____

Student Name: _____ Grade & Teacher: _____

Parent/Guardian Name: _____ Phone #: _____

Current Bus # of student: _____ Current Bus Stop: _____

Note other siblings in district grades/buildings: _____

_____ Parent/Guardian signature: _____

Date Parent/Guardian request transportation/transfer to START ____/____/____
(Must be 3 days from date of request)

Frequency of Transfer: (Please circle all that apply)
(Days of Week) (Time of Day)

M T W TH F AM NO LEAP DAYS

M T W TH F PM NO LEAP DAYS

AM Requested Bus Stop: _____

PM Requested Bus Stop: _____

If request is for childcare provider, please supply information below:

Name of childcare provider: _____ Phone #: _____

OFFICE USE ONLY:

Requested Approval: YES _____ NO _____ Bldg. Approval _____

Transportation Department Notified: YES _____ Transportation Official _____ Date ____/____/____

Building notified: Homeroom Teacher _____ Parent/Guardian _____ Date ____/____/____

Transportation Notified: Bus Driver(s) _____ Building Secretaries _____ Date ____/____/____

Date Request Will Take Effect: ____/____/____ New AM bus stop: _____

New PM bus stop: _____

New AM bus #: _____ AM P/U Time: _____ Time is approximant

New PM bus #: _____ PM D/O Time: _____ Time is approximant



Eldon Middle School

Shaun Fischer, Principal
Ski Hull, Assistant to the Principal/AD
1400 North Grand Eldon, Missouri 65026
Phone 573.392.8020 Fax 573.392.9151



RELEASE OF STUDENT'S SCHOOL RECORD PERMISSION FORM

DATE _____

STUDENTS FULL NAME _____

DOB _____

GRADE _____

NAME OF SCHOOL LAST ATTENDED _____

SCHOOL FAX NUMBER _____

STREET ADDRESS _____

SCHOOL PHONE NUMBER _____

CITY _____

STATE _____

ZIP CODE _____

To enable us to complete our records, please send the following information:

1. A record of scholastic achievement
2. Health records.
3. Scores on intelligence and achievement
4. Diagnostic Summary and IEP, if applicable
5. Discipline records

Band :

Choir :

Sped :

Math :

The Family Rights and Privacy Act, Buckley Amendment, Section 99.30, Paragraph (b) states that schools where a student intends to enroll DO NOT need to have a consent form signed for transfer of school records.

Please return this information to: Eldon Middle School

Attn: Office Personnel

1400 North Grand

Eldon, MO 65026

Email: Shyla.Prater@EldonMustangs.org

Phone #: (573) 392-8020

Fax #: (573) 392-9151

PARENT/GUARDIAN SIGNATURE _____

DATE _____

ELDON R-I SCHOOLS ENROLLMENT INFORMATION
2019-2020

Date _____

Race: (please check) White _____ Black _____ Hispanic _____ Indian _____ Asian _____ Other _____

Student's Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ Zip Code: _____

IF PO BOX is used, please list actual street address above: PO BOX # _____

Home Phone #: _____ Cell #: _____ E-mail Address: _____

Grade _____ Male _____ Female _____

Parent/Guardian (in home) or whom you are living: _____ Are you a registered voter? YES NO

Parent 1 Information: _____ Relation: _____

Employer: _____ Work #: _____ Cell #: _____

Parent/Guardian 2 Information _____ Relation: _____

Employer: _____ Work #: _____ Cell #: _____

Parent/Guardian E-mail Address: _____

Please list all siblings in Eldon Schools and their ages: _____

Are there currently any court orders dealing with custody or visitation? YES NO

IF YES, please provide the school with a copy. We CANNOT honor without documentation.

Emergency Contacts:

1. Name _____ Relation: _____ Phone #: _____ Cell: _____

2. Name _____ Relation: _____ Phone #: _____ Cell: _____

Name of Parent out of the home (if applicable): _____ Relation: _____ Home #: _____

Employer: _____ Work #: _____ Cell #: _____

Would this parent like a grade card sent to them? YES NO If yes please provide address

Previous school attended (name of school in what State): _____

Previous school address: _____ Phone #: _____

Circle the county in which you live: MILLER MORGAN MONITEAU

Circle the district in which you live: ELDON R-I HIGH POINT OTHER

Does the student use a language other than English? YES NO If YES, what language? _____

Is a language other than English used in the home? YES NO If YES, what language? _____

Are you or an immediate family member in the Military? (circle one) Active Duty National Guard or Reserve Unknown

Are you currently living in a temporary residence because your home has been damaged or economic hardship? (e.g. motel, hotel, car, campsite, shelter)? YES NO

Are you currently living with another family (doubled up) due to loss of housing, economic hardship, or a similar reason? Explain if it is a similar reason. YES NO Explain: _____

Has your family moved within the past 3 years to seek or obtain temporary or seasonal agricultural or food processing work? YES NO

____ My signature below signifies I give permission for my child to go on school or classroom trips during the elementary school years. I will be responsible to notify the school, in writing, if I want to change my position on my child attending field trips during his/her elementary years.

____ I give permission for any local newspaper staff or school district to photograph my child and/or to publish his/her work to social media.

____ My signature below signifies if I cannot be reached in the event of an emergency, I give consent for the school to obtain, through a physician or hospital of its choice, such medical care as is reasonably necessary for the student. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Eldon R-1 School District
Voluntary Student Demographic Information

The Eldon R-1 School District is requesting that this form be completed by the student or the student's parent. Completion of this form is voluntary. The district is required to submit an aggregate report on the ethnicity and race of all students in the district. The most accurate information comes from you. If this form is not completed, the district will be forced to assign each student to an ethnicity and race category based on whatever information the district has available, including visual observation.

Collection of this information is authorized by federal law, and the information collected will be used to satisfy federal and state reporting requirements and better serve the students of our district. All information provided will be kept confidential in accordance with law.

STUDENT NAME: _____

Is the student Hispanic or Latino?

____ Yes, Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South American, Central American or other Spanish culture of origin, regardless of race)

____ No, not Hispanic or Latino

What is the student's race?

____ American Indian or Alaska Native (a person having origins in any of the original peoples of North America or South America, including Central America, and who maintains tribal affiliation or community attachment)

____ Asian (a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)

____ Black or African American (a person having origins in any of the black racial groups of Africa)

____ Native Hawaiian or Other Pacific Islander (a person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands)

____ White (a person having origins in any of the original peoples of Europe, the Middle East or North Africa)

OPTIONAL PARENT PORTAL ACCESS

Through this web-based system, Parent Portal, parents will be able to view their child's attendance history, schedule and grades based on three week progress reports.

Information for your child is available only with a password. All passwords are distributed through email. It will be your responsibility to keep this password private. We cannot issue any passwords via phone conversation. Passwords will not be issued to the student. You must have an email address to view your child's records in PARENT LINK.

Please provide the email address that you would like to use for student information notifications. You may use only one email address, for example, home or work, but email cannot be sent to both. Please fill in the correct email address on the line provided. This form must be submitted each school year for you to have access.

PLEASE PRINT BELOW

Student Name

Parent Name

Parent Email Address—Home or Work (circle one)

Parent Name

Parent Email Address—Home or Work (circle one)

_____ I would like to be able to access my student's information over the Internet by using a password.

_____ I do not want access to my student's information available over the Internet.

I understand that it is my responsibility to protect my PARENT LINK password. I should not share my password with my children. I understand that the PARENT LINK system may not be available 24 hours a day due to maintenance on the school network, weather related interruptions, etc.

Parent Printed Name

Parent Signature

Date

Please return this letter to the ECC office. Please provide a copy of a picture ID.

Cheyenne Uptergrove

Eldon R-I

SIS Coordinator

112 S. Pine

Eldon, MO 65026

(573) 392-8000

ICU Database

At the Middle School we use a program called the ICU Database. This program allows us to notify you through text message and email that your student is missing an assignment. The term ICU may seem alarming to some, but the intention is to take students' work as seriously as we take their health. Missing assignments devastate a grade in much the same way that a virus devastates the immune system.

When we place a student on "the list," not only are you notified, but the entire staff can see that the student needs to complete an assignment. Now instead of one teacher being responsible for caring about the missing assignment, the entire building (including coaches, counselor, tutors, etc.) can help to guide the student's grade back to good health.

The fundamental goal of this program is to build an army of support behind the students. We want to keep you informed of your students' progress in real time. To do this we are asking you to give us the best phone number and email addresses to contact you. If you have another person that is better to contact feel free to list their number or email instead. Please know that when a student is on the list they are not "in trouble", rather it allows both parents and the school to take preventative action from failing grades.

Student's name: _____

Name of person to text: _____

Relation to student: _____

Phone number (for text messages): _____

Please list the names of the two best people to email.

Email 1: _____

Name/Relation: _____

Email 2: _____

Name/Relation: _____



Eldon School District

Matt Davis, Superintendent

Rigor - Relevance - Relationships

ELDON R-1 SCHOOLS

For the past several years, Eldon R-1 Schools has been pleased to be able to provide Eldon parents with automated phone notifications of important events such as upcoming events, notice of information sent home with students, inclement weather school closings and similar information. We will continue to provide this information as a service for our parents.

Parents who do not wish to continue to receive non-emergency information must opt-out to not receive calls. Only emergency calls will be received.

By signing this form, you are indicating that we should remove you from all non-emergency calls sent out by the district.

Check the appropriate box below:



I do not give my permission to receive non-emergency calls from Eldon R-1 Schools using automatic dialing equipment at the telephone numbers submitted during the registration process.

Student Name _____

Parent's Signature _____

ENROLLMENT AFFIRMATION FOR PARENT
OR COURT-APPOINTED GUARDIAN
(Resident Student with No Prior Expulsions)

Under penalty of law, I affirm that I am the parent or court-appointed legal guardian of the minor student, _____, that I reside within the boundaries of the **ELDON R-1 School District** and the student resides within the boundaries of such district, and that any information or documentation that I have provided as proof of residency is true and correct to the best of my knowledge, information and belief. I further affirm that the student, _____, has not been expelled from school attendance at any other school in the state or in any other state for an offense in violation of school policies related to weapons, alcohol or drugs, or the willful infliction of injury to another person, and that the other information that I have provided to the school district is true and correct to the best of my knowledge, information and belief. I understand that this statement will be maintained as part of the student's scholastic record.

I understand that it is a criminal violation to make a materially false statement or affirmation, or to provide false information to establish residency, and that if I have provided false information for such purpose, the school district may file a civil action against me to recover cost of educating the student.

Signature of parent or court-appointed guardian

Subscribed and affirmed before me this _____ day of

_____, _____.

Signature of Notary Public and Official Seal

Grade: _____

Address: _____

Phone #: _____

Bus # _____

Directory Information

Eldon School District

Please sign and return this for to the main office of your student's school ONLY IF YOU DO NOT want information about your student released.

You have the right to choose whether your student's directory information is released or not. If you want to limit the disclosure of directory information of child, please sign below and return this form to your student's school. This form applies to the 2019-2020 school year only.

**** Directory information may be prepared for mass release (school yearbook, school directory, athletic programs, summer camps, businesses, church, military recruiters, ect.) unless parents, guardians, or eligible students indicate they do not wish for the information to be disclosed. Directory information means information contained in a education record of a student that would not generally be considered harmful or an invasion of privacy of disclosed. It includes, but is not limited to:**

Name of students

Present Address

Electronic mail address

Telephone number

Student ID numbers/ User IDs

Name of parent/guardian

Photograph

Date of attendance

Grade Level

Enrollment status

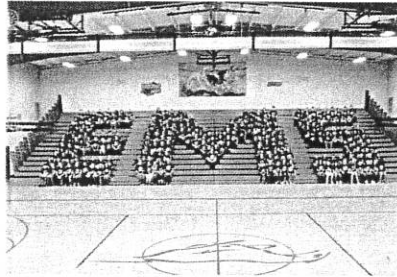
I am requesting that directory information for the 2019-2020 school year regarding _____ NOT be released.

Print Student's name

Parent/ Guardian Signature

Date

**Eldon Middle School
Supply List
2019-2020**



All 7th and 8th Grade Classes

Pencils

Loose Leaf paper

2 Boxes of Kleenex (turned into homeroom teacher)

7th Grade

Pre- Algebra 1 composition notebook, pocket folder with prongs. Optional: Scientific Calculator (TI30x11s)

Math – 1 composition notebook, Optional: Scientific Calculator (TI30x11s)

English – 2 inch 3 ring binder, 1 pack of dividers, 1 spiral notebook

Science – 1 composition notebook

Social Studies – 1 pocket folder, spiral notebook

Family and Consumer Science (FACS) – 1 pocket folder

Physical Education (PE) – 1 pocket folder (Health class), shorts, t-shirt, tennis shoes

8th Grade

Algebra- 1 composition notebook, pocket folder with prongs. Optional: Scientific Calculator (TI30x11s)

Math – 1 composition notebook, Optional: Scientific Calculator (TI30x11s)

English – 2 inch 3 ring binder, 1 pack of dividers, 1 spiral notebook

Science – 1 composition notebook, 1 pocket folder

Social Studies – 1 pocket folder, spiral notebook

Family and Consumer Science (FACS) – 1 pocket folder

Physical Education (PE) – 1 pocket folder (Health class), shorts, t-shirt, tennis shoes

** This is a list of minimum requirements. Students may choose to use other supplies as well; trapper keeper, pens, erasers, etc.

The Missouri Virtual Instruction Program (MOVIP) transitioned to the Missouri Course Access and Virtual School Program (MOCAP) as a result of updates to [Section 161.670, RSMo](#). Information about state funding for students enrolled in virtual education can be found in [Section 162.1250, RSMo](#). Missouri students may enroll in MOCAP courses for the fall and spring semesters. MOCAP is not available in the summer.

What Is a MOCAP Course?

[Section 162.1250, RSMo](#) sets out the requirements for all virtual courses. Not all virtual courses are approved MOCAP courses. Courses listed on the MOCAP Course Catalog have been checked for compliance by the Department of Elementary and Secondary Education (DESE). The local education agency (LEA) must vet all other virtual courses to ensure that statutory requirements have been met. In order for students to enroll in MOCAP courses, LEAs must have a secure method to send a student's MOSIS ID and date of birth to courseware providers.

MOCAP courses have been through a stringent review process, including:

- Course alignment to Missouri Learning Standards
- Web Content Accessibility Guidelines (WCAG 2.0)
- Data security review
- Missouri appropriately certificated teachers
- College Board approval of Advanced Placement (AP) courses in the catalog

MOCAP providers have agreed to:

- reporting requirements (including course completion and learning gains)
- invoicing requirements
- a price cap of 7% per semester and 14% per year, per course, based on the June State Adequacy Target

Course Catalog

MOCAP's course catalog link, mocap.mo.gov/catalog/ displays contact information for providers to be contacted directly to register for courses.

MOCAP Policies

An LEA shall inform parents of their child's right to participate in the program. Availability should be made clear in the parent handbook, registration documents, and featured on the LEA's homepage.

Individual Learning Plans (ILP) or Individual Career and Academic Plans (ICAP) Students taking more than two MOCAP courses must have an individualized learning plan maintained in the LEA's student records. An LEA may develop its own learning plan for students or use the [ICAP](#) that is available through the Office of College and Career Readiness under School Counseling.

Student's Appeal Process

There is an appeal process if a student is denied access to a MOCAP course. Please refer to [Section 161.670, RSMo](#) to learn about the LEA's responsibility in the MOCAP appeal process. Parent/guardians must first work with the LEA before submitting the appeal to DESE. Parents/guardians may only submit the documentation provided by the local school board to the [MOCAP Appeal](#) website. The LEA will receive notification of the appeal and a copy of the submitted documentation. Only MOCAP courses offered during the regular school year are eligible for appeal. The appeal process does not apply to summer school or virtual courses that are not MOCAP approved.

MOSIS – August Core Data Cycle, Screen 3

The contact person entered on Screen 3 will receive information about MOCAP appeals and updates to the program. Please ensure this contact is accurate. It is critical that this information is always current.

Reporting for Virtual Education in MOSIS

- MOCAP requires that all teachers be appropriately certificated. Attendance hours for any educator without a valid Missouri teaching certificate will not be allowed for state aid purposes.
- Virtual courses will use Exhibit 34 – Instruction via Technology for delivery systems.

Program Code 50 in MOSIS

- LEAs will identify MOCAP courses with Program Code 50 in their MOSIS October Cycle – Course Assignment.
- For student courses identified with the Program Code of 50, the educator course and educator do not need to be reported in the Course Assignment, Educator Core, or the Educator School files because the appropriate certification has already been verified by MOCAP.

Program Code 52 – Curriculum Only in MOSIS

- LEAs will identify MOCAP curriculum only with Program Code 52- in their MOSIS October Cycle – Course Assignment.
- For MOCAP curriculum-only courses, an LEA must use an appropriately certificated teacher
- For courses that do not have a MOCAP teacher, the LEA will report educator information in the MOSIS October Cycle – Educator Core and Educator School.
- If an LEA does not have an appropriately certificated teacher, the course cannot be reported as a MOCAP course. Therefore, do not enter a program code; enter only the delivery system from Exhibit 34.

LEAs as Courseware Providers That Are NOT in the MOCAP Course Catalog

- [Section 162.1049, RSMo](#) requires nonresident district and resident district shall accept each other's credits.
- LEAs may develop and provide online courses for other LEAs if standards in [Section 162.1250, RSMo](#) have been met.
- When purchasing virtual education from a Missouri LEA, the educating LEA (receiving) must coordinate with the sending LEA (where the student is enrolled) under the Cooperative Agreement - Resident 1.
- These are not MOCAP courses, so do not enter a program code; enter only the delivery system from Exhibit 34.

For more information about MOCAP, please contact DESE.MOCAP@dese.mo.gov or 573-522-3651 or visit the [MOCAP website](#).