

School _____

Returning Student Information

Student Lives with () Both Parents () Mother () Father () Legal Guardian () Foster Parent

Student Name _____ Grade ____ DOB ____ Gender () Male () Female
Last First MI

Home Address/Physical _____ District _____

Mailing Address _____ City _____ State _____ ZIP _____

Primary Contact Phone Number (only one phone number) _____

Parent(s)/Guardian (s) Email Address _____

Parent / Guardian Information

Parent's Marital Status () Married () Single () Divorced () Widowed () Separated

Parent/Guardian 1 _____ Parent Guardian 2 _____

() Mother () Father () Step-Mother () Step Father () Other () Mother () Father () Step-Mother () Step Father () Other

Employer _____ Work Phone _____ Employer _____ Work Phone _____

Home Phone _____ Cell _____ Home Phone _____ Cell _____

Is this parent/guardian Active Military () Yes () No Is this parent/guardian Active Military () Yes () No

Other Emergency Contact Information (list someone not listed above)

Name _____ Name _____

Relationship to Student _____ Relationship to Student _____

Home Phone _____ Home Phone _____

Work Phone _____ Cell _____ Work Phone _____ Cell _____

Transportation Instructions Grades K – 8

My child will ride the bus: _____ My Child will Ride the Bus
Bus route # _____ My child will walk home
Bus Stop _____ I will provide transportation
May walk home from bus stop () Yes () No (check all that apply above)
Must be met at bus stop () Yes () No
By whom: _____

Transportation Instructions Grades 9-12

My student will ride the bus () Yes () No _____ Parent will provide transportation to & from school.
Bus route _____

Student Name _____

Returning Student Information

Tribal Affiliation

- | | | |
|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Gila River Indian Community | <input type="checkbox"/> Pascua Yaqui Tribe |
| <input type="checkbox"/> Ak-Chin Indian Community | <input type="checkbox"/> Havasupai Tribe | <input type="checkbox"/> Pueblo of Zuni |
| <input type="checkbox"/> Cocopah Indian Tribe | <input type="checkbox"/> Hopi Tribe | <input type="checkbox"/> Quechan Tribe |
| <input type="checkbox"/> Colorado River Indian Tribes | <input type="checkbox"/> Hualapai Tribe | <input type="checkbox"/> Salt River Pima-Maricopa Indian Community |
| <input type="checkbox"/> Fort McDowell Yavapai Nation | <input type="checkbox"/> Kaibab Band of Paiute Indians | <input type="checkbox"/> San Carlos Apache Tribe |
| <input type="checkbox"/> Fort Mojave Indian Tribe | <input type="checkbox"/> Navajo Nation | <input type="checkbox"/> San Juan Southern Paiute |
|
 | | |
| <input type="checkbox"/> Tohono O'dam Nation | | |
| <input type="checkbox"/> Tonto Apache Tribe | | |
| <input type="checkbox"/> White Mountain Apache Tribe | | |
| <input type="checkbox"/> Yavapai-Apache Nation | | |
| <input type="checkbox"/> Yavapai-Prescott Indian Tribe | | |
| <input type="checkbox"/> Other: _____ | | |

As the parent/legal guardian of the student, I attest that I am a resident of the state of Arizona per A.R.S 15-802 (B) and I certify the information provide on this form is correct.

Parent/Legal Guardian Signature _____ Date _____

Office Use Only:

Entry Date _____ Entry Code _____
Entry Date in Powerschool _____ Entered into Powerschool by (initials) _____

EXHIBIT

USE OF TECHNOLOGY RESOURCES
IN INSTRUCTION

ELECTRONIC INFORMATION SERVICES
USER AGREEMENT

Details of the user agreement shall be discussed with each potential user of the electronic information services (EIS). When the signed agreement is returned to the school, the user may be permitted use of EIS resources.

Terms and Conditions

Acceptable use. Each user must:

- A. Use the EIS to support personal educational objectives consistent with the educational goals and objectives of the School District.
- B. Agree not to submit, publish, display, or retrieve any defamatory, inaccurate, abusive, obscene, profane, sexually oriented, threatening, racially offensive, or illegal material.
- C. Abide by all copyright and trademark laws and regulations.
- D. Not reveal home addresses, personal phone numbers or personally identifiable data unless authorized to do so by designated school authorities.
- E. Understand that electronic mail or direct electronic communication is not private and may be read and monitored by school employed persons.
- F. Not use the network in any way that would disrupt the use of the network by others.
- G. Not use the EIS for commercial purposes.
- H. Follow the District's code of conduct.
- I. Not attempt to harm, modify, add/or destroy software or hardware nor interfere with system security.
- J. Understand that inappropriate use may result in cancellation of permission to use the educational information services (EIS) and appropriate disciplinary action up to and including expulsion for students.

In addition, acceptable use for District employees is extended to include requirements to:

- A. Maintain supervision of students using the EIS.
- B. Agree to directly log on and supervise the account activity when allowing others to use District accounts.
- C. Take responsibility for assigned personal and District accounts, including password protection.
- D. Take all responsible precautions, including password maintenance and file and directory protection measures, to prevent the use of personal and District accounts and files by unauthorized persons.

Personal responsibility. I will report any misuse of the EIS to the administration or system administrator, as is appropriate.

I understand that many services and products are available for a fee and *acknowledge my personal responsibility for any expenses incurred without District authorization.*

Network etiquette. I am expected to abide by the generally acceptable rules of network etiquette. Therefore, I will:

- A. *Be polite and use appropriate language.* I will not send, or encourage others to send, abusive messages.
- B. *Respect privacy.* I will not reveal any home addresses or personal phone numbers or personally identifiable information.

C. *Avoid disruptions.* I will not use the network in any way that would disrupt use of the systems by others.

D. *Observe the following considerations:*

1. Be brief.
2. Strive to use correct spelling and make messages easy to understand.
3. Use short and descriptive titles for articles.
4. Post only to known groups or persons.

Services

The School District specifically denies any responsibility for the accuracy of information. While the District will make an effort to ensure access to proper materials, the user has the ultimate responsibility for how the electronic information services (EIS) is used and bears the risk of reliance on the information obtained.

I have read and agree to abide by the School District policy and regulations on appropriate use of the electronic information system, as incorporated herein by reference.

I understand and will abide by the provisions and conditions indicated. I understand that any violations of the above terms and conditions may result in disciplinary action and the revocation of my use of information services.

Name _____

Signature _____ **Date** _____
(Student or employee)

School _____ **Grade (if a student)** _____

Note that this agreement applies to both students and employees.

The user agreement of a student who is a minor must also have the signature of a parent or guardian who has read and will uphold this agreement.

Parent or Guardian Cosigner

As the parent or guardian of the above named student, I have read this agreement and understand it. I understand that it is impossible for the School District to restrict access to all controversial materials, and I will not hold the District responsible for materials acquired by use of the electronic information services (EIS). I also agree to report any misuse of the EIS to a School District administrator. (Misuse may come in many forms but can be viewed as any messages sent or received that indicate or suggest pornography, unethical or illegal solicitation, racism, sexism, inappropriate language, or other issues described in the agreement.)

I accept full responsibility for supervision if, and when, my child's use of the EIS is not in a school setting. I hereby give my permission to have my child use the electronic information services.

Parent or Guardian Name (print) _____

Signature _____ **Date** _____



**Arizona Department of Education
Arizona Residency Documentation Form**

Student _____ School _____

School District or Charter Holder _____

Parent/Legal Guardian _____

As the Parent/Legal Guardian of the Student, I attest* that I am a resident of the State of Arizona and submit in support of this attestation a copy of the following document that displays my name and residential address or physical description of the property where the student resides:

- _____ Valid Arizona driver's license, Arizona identification card or motor vehicle registration
- _____ Valid Arizona Address Confidentiality Program authorization card
- _____ Real estate deed or mortgage documents
- _____ Property tax bill
- _____ Residential lease or rental agreement
- _____ Water, electric, gas, cable, or phone bill
- _____ Bank or credit card statement
- _____ W-2 wage statement
- _____ Payroll stub
- _____ Certificate of tribal enrollment (506 Form) or other identification issued by a recognized Indian tribe in Arizona
- _____ Documentation from a state, tribal or federal government agency (Social Security Administration, Veteran's Administration, Arizona Department of Economic Security)
- _____ Temporary on-base billeting facility (for military families)

_____ I am currently unable to provide any of the foregoing documents. Therefore, I have provided an original affidavit signed and notarized by an Arizona resident who attests that I have established residence in Arizona with the person signing the affidavit.

Signature of Parent/Legal Guardian

Date

*For members of the armed services, the provision of verifiable documentation does not serve as a declaration of official residency for income tax or other legal purposes. Armed service members may utilize a temporary on-base billeting facility as the address for proof of residency.



**State of Arizona
Affidavit of Shared Residence**

Student Name: _____

Parent/Legal Guardian Name: _____

School Name: _____

School District or Charter Holder: _____

Name of Arizona Resident: _____

I, (resident name) _____ swear or affirm that I am a resident of the State of Arizona and that the persons listed below reside with me at my residence, described as follows:

Persons who reside with me: _____

Location of my residence: _____

I submit in support of this attestation a copy of the following document that displays my name and current residence address or physical description of my property:

- _____ Valid Arizona driver's license, Arizona identification card or motor vehicle registration
- _____ Valid Arizona Address Confidentiality Program authorization card
- _____ Real estate deed or mortgage documents
- _____ Property tax bill
- _____ Residential lease or rental agreement
- _____ Water, electric, gas, cable, or phone bill
- _____ Bank or credit card statement
- _____ W-2 wage statement
- _____ Payroll stub
- _____ Certificate of tribal enrollment (506 Form) or other identification issued by a recognized Indian tribe in Arizona
- _____ Documentation from a state, tribal or federal government agency (Social Security Administration, Veteran's Administration, Arizona Department of Economic Security)

Printed Name of Affiant: _____

Signature of Affiant: _____

Acknowledgement

State of Arizona

County of _____

The foregoing was acknowledged before me this ___ day of _____, 20 ,

By _____

My Commission Expires:

Notary Public

San Carlos Unified School District McKinney-Vento Intake Affidavit

Student's Name: _____ ID# _____

Date of Birth: _____ Age: _____ Grade: _____ Sex: _____

Parent/Guardian Name(s): _____

Phone number(s): _____

Address: _____

Home School (based on current residence): _____

School of Origin (last school attended): _____

Siblings of student:

Name	School
_____	_____
_____	_____
_____	_____

Please answer the following questions:

1. Is this student's home address a temporary living arrangement? Yes No
2. Is this a temporary living arrangement due to loss of housing or economic hardship? Yes No
3. Is this student in temporary or emergency foster care placement? Yes No
4. As a student, are you living with someone other than your parent or legal guardian? Yes No

If you answered YES to **any** of the above questions, please complete the remainder of this form.

If you answered NO to all of the above questions, you may stop here.

1. Where is this student currently living? (*check box*)

In a motel/hotel- Name of motel/hotel: _____

In a shelter- Name of shelter: _____

Transitional Housing- Name of transitional housing: _____

Group Home- Name of group home: _____

Temporary/emergency foster home

With more than one family in a house or apartment

Moving from place to place

In a location not designed for sleeping accommodations such as a car, park, or campsite

2. How long have you lived at this residence? _____

3. How long do you plan to live at this residence? _____

4. With whom does the student currently live: (*check box*)

Both parents

One parent- Which parent? _____

One parent and another adult- Which parent? _____

A relative- Specify which (e.g. grandmother) _____

Friends or other adults- please identify _____

An adult who is not a parent or legal guardian- please identify _____

5. Describe the current living situation in detail: _____

6. Any possibility of violence or abuse in home? If so, describe. What were the school's actions?

7. In your child's previous school, did he/she receive any of the following? *(check all that apply)*

Special Education/Exceptional Children's Services- Describe: _____

504 Accommodation Plan- Describe: _____

English As a Second Language (ESL) services

Help for Behavior Improvement

Tutoring Services

Academically or Intellectually Gifted services

Counseling services

8. At this time, what is the greatest need for your child? *(check all that apply)*

School supplies

School uniform or clothing

Help for academic improvement

Help for behavior improvement

Referral for food assistance

Medical referral/immunizations

Mental health/counseling referral

Other- Please describe: _____

My signature below affirms the following: (1) the information I have provided on this form is true and accurate to the best of my knowledge or belief; (2) the same information, as well as other information that may identify my child(ren), may be shared without my consent with community and governmental agencies pursuant to an interagency collaboration between this school district, A Child's Place; and, (3) the same information, as well as other information that may identify my child(ren), may be shared without my consent with other CMS staff members for a legitimate educational purpose. In addition, my signature affirms that I have received a copy of my rights under the McKinney-Vento law and I agree to allow CMS staff to conduct screenings as a part of the district's McKinney-Vento program.

Parent/Guardian Signature: _____

(Or Unaccompanied Youth)

Date: _____



SAN CARLOS UNIFIED SCHOOL DISTRICT NO. 20

We exist to educate and empower students to become culturally responsive, global learners.

HEALTH OFFICE INFORMATION - SY2021-2022

The Health Office Staff welcomes new and returning students to San Carlos Unified School District. To assist in providing the quality care your student deserves, please COMPLETE this packet and return to health office staff at your student's school.

School Year : 2021-2022

Grade: _____

Student Name _____ Date of Birth _____

Phone: Home _____ Cell _____ Work _____

Mailing Address: _____

Physical Address _____

Emergency Contacts: Please list contact information for individuals you trust to make decisions about the health care provided to your student and that you would allow your student to go home with if you are unavailable:

1. Name _____

Address: _____

Phone: _____

2. Name _____

Address: _____

Phone: _____

3. Name _____

Address: _____

Phone: _____

San Carlos Unified School District No 20



We exist to educate and empower students to become culturally responsive, global Nn'ee.

JLCC © - COMMUNICABLE / INFECTIOUS DISEASES

Any student with, or recovering from, a communicable disease will not be permitted in school until the period of contagion is passed or until a physician recommends a return, in accordance with A.R.S. [36-621 et seq.](#), appropriate regulations of the State Department of Health Services, and policies of the County Health Department.

Parents will be requested to provide a history of the communicable diseases for each student, and such records will be kept and maintained by the District.

A student suffering from a communicable disease shall be excluded from school to protect the student's own welfare and also to protect other students from illness. Early recognition of a communicable disease is of prime importance. The administrator or county health director shall make the decision for exclusion and readmission.

Pediculosis (Lice Infestation)

Students with pediculosis shall be excluded from school until treated with a pediculicide.

Adopted: June 13, 2017

I confirm that I have read, understand and agree to the above policy and procedure for enrollment in the San Carolus Unified School District No 20.

Parent/Guardian Name – Please Print

Student Name

Grade

Parent/Guardian Signature

Date

Our Vision Statement- We will become an effective student focused learning community graduating culturally confident citizens.

P.O.BOX 207 ~San Carlos Avenue~San Carlos, Arizona 85550 Phone (928) 475-2315, Fax (928) 475-2301

Student Name: _____ Date of Birth _____

San Carlos School District No. 20 Health Office Information

SY 2021-2022

Here at the San Carlos School District we try to provide a safe environment for the students and staff, often basic first aid is practiced to ensure the safety of our students and staff.

Arizona State Law prohibits us from treating any condition without written permission from the parents and/or guardians.

The health office staff will contact you in cases that require your child to be sent home.

Below is a list of over-the-counter medications that can be provided to your student in the event his/her symptoms deem it necessary:

- | | | |
|----------------------------|--|--------------------------------------|
| Tylenol (acetaminophen) | Hydrocortisone cream (skin irritation) | Bacitracin ointment (cuts/scratches) |
| Oral pain relief gel | Saline eye wash | Lice shampoo (individual basis) |
| Hand Lotion | Saline eye drops | Lip balm |
| Tums (antacid tablets) | Cough drops | Seasonal Allergy Medication |
| Benadryl Cream (anti-itch) | | Vaseline (dry skin) |

Information on past medical history/health concerns would be helpful in providing the best care for your child: Please indicate whether or not your student has experienced any of the following conditions:

Seasonal Allergies Yes___ No___	Heart Condition Yes___ No___	Seizures (Epilepsy) Yes___ No___	Chronic Ear Infections Yes___ No___	Vision Concerns Yes___ No___
Hearing Concerns Yes___ No___	Asthma** Yes___ No___ ***See Next Page	History of Chicken Pox Yes___ No___	Weakened Immune System Yes___ No___	Food, Medication, or Bee Allergy*** Yes___ No___ ***See next page

If you answered yes to any of the above conditions please explain:

DOES YOUR CHILD TAKE DAILY MEDICATIONS? YES _____ NO _____ If your child requires medication during school hours you must see the SCHOOL HEALTH OFFICE STAFF to sign a medication consent form; your child will not be given medication until the medication consent is signed. The medication must be delivered to health office in the **ORIGINAL** Prescription Bottle with the student's name listed, the name of the medication and prescription doctors name. Governing Board Policy JLCD.

I: _____ give permission for health office staff to provide my student first aid care, any medication listed above and/or call the local Emergency Medical Transport service in the event of an emergency during school hours.

Parent/Guardian signature: _____ Date: _____

Student Name _____ Date of Birth _____

SAN CARLOS UNIFIED SCHOOL DISTRICT NO.20
PARENT CONSENT TO ADMINISTER MEDICATION AT SCHOOL

I hereby request and give my consent for school nurse or person designed by the school administrator to see that my child receives the medication as indicated below.

The medication is to be furnished by me in the original Container with a pharmacy labels prescribed below:

1. Name of medication _____
2. Route of administration (by mouth, etc.) _____
3. Amount to be given _____
4. Time of day to be given _____
5. Length of time to be given (a week, etc.) _____
6. Physician's name (from label) _____
7. Reason for medication _____

Parent Signature _____ Date _____

Nurse's Signature _____ Date _____

Comments: _____

Emergency Care and Medication

Asthma/Reactive Airway Disease

If your student has Asthma, it is recommended they have an inhaler at school (if prescribed). The Health Services offices have Albuterol nebulizer treatments available for students experiencing severe shortness of breath. School Health Personnel will attempt to contact you prior to administering Albuterol and update you on your student's condition after administration and if further medical services will be required.

By signing below you give SCUSD Health Services Personnel permission to administer Albuterol nebulizer treatment for your student with Asthma who is experiencing severe shortness of breath with dose determined by the student's weight.

Student Name _____ Date of Birth _____

Parent/Guardian Signature: _____ Date _____

Provider Signature: _____ Date _____

Severe Food and Bee Allergies

If your student has Severe Food or Bee Allergies, it is recommended they have an Epi Pen at school (if prescribed). The Health Services offices have Epi Pens treatments available for students experiencing severe Allergic Reactions. School Health Personnel will attempt to contact you prior to administering Epi Pen and update you on your student's condition after administration. If an Epi Pen is administered to your student, EMS will be contacted to transport your student to the Emergency Room for evaluation and continued treatment.

By signing below you give SCUSD Health Services Personnel permission to administer Epi Pen for treatment for your student with Severe Allergic Reaction who is experiencing a Severe Allergic Reaction with dose determined by the student's weight.

Student is allergic to: _____

Student Name _____ Date of Birth _____

Parent/Guardian Signature: _____ Date _____

Provider Signature: _____ Date _____