107 N.W. 10th Street
Pendleton, OR 97801
Ph: 541-276-6711
Fax: 541-278-3208
www.pendleton.k12.or.us

Kindergarten Registration Checklist

WELCOME to the Pendleton School District Kindergarten Registration! Attached you will find forms necessary to register your student for the upcoming school year.

- ☐ 1. **REGISTATION FORM** – Please make sure your child's LEGAL name (as shown on the birth certificate) is filled out on the first line. If your child goes by a different last name other than their legal last name, we are happy to use that name for classroom purposes. However, all mailings and report cards will be issued under your child's legal name. **Please fill out both sides of this form.**

- ☐ 2. **CERTIFICATE OF IMMUNIZATION STATUS FOLDER** – Please fill out your child's name and then sign and date at the bottom. A copy of the immunization records can be attached without you filling out the dates. Once your student's immunization information is recorded, a letter will follow informing you of any additional shots your child may need.

- ☐ 3. **KINDERGARTEN HEALTH DEVELOPMENTAL AND SOCIAL HISTORY FORM**– If your child has ANY allergies and medication that must be given at school, or custodial concerns, please indicate in the appropriate place and bring this to our attention when returning these forms.

- ☐ 4. **DENTAL Form**

- ☐ 5. **HOME LANGUAGUE SURVEY Form**

- ☐ 6. **RACE and ETHNICITY Form**

- ☐ 7. **COMPUTER TECHNOLOGY Form**

- ☐ 8. **SPECIAL NEEDS CHILD FIND Notice**

- ☐ 9. **MID-COLUMBIA BUS COMPANY, INC Form**

- ☐ 10. **BIRTH CERTIFICATE** – Please provide the school with a photocopy of your child's **Certified Birth Certificate or provide proof of birth from another country**. If you need to order a birth certificate and your child was born in Oregon, you may call Oregon Vital Statistics at (971) 673-1190 or go to their website: www.oregon.gov/DHS/ph/chs/order/faqs.shtml

  If your child was born out of state, you may call information for that state and ask for the Bureau of Vital Statistics. If ordering a birth certificate from another country, please go to http://travel.state.gov Please supply the office with a copy prior to the start of school.

- ☐ 11. **SOCIAL SECURITY NUMBER**

Although you may not have **all** the information to fill these forms out now, **please return completed forms to the school office,** so we can start the registration process. If you have any questions, please call Lori Curtis at 541-966-3300.

Pendleton School District 16R
Registration Form

Legal Last Name	First Name	Middle Name

Student Information:

Grade____ Gender (circle) M F Birth Date:_____ Social Security #_____

Birth Place_____/_____/_____ Mother's Maiden Name_____
(City) (State) (Country)

Migrant #_____

Last School/Preschool Attended:
Address:
City & State: **Phone:** **Fax:**
Services or Programs (Check all that may apply): ❑Title I Support ❑Medical or Medication Supports ❑ 504 Accommodations ❑IEP/IFSP/Special Education ❑English Learner Services ❑Homeless Youth Services ❑Behavior Services ❑Counseling ❑Migrant ❑ Other:_____

It is the responsibility of the parent/guardian to provide the school with any legal documentation or court orders that apply to the student and are relevant to the child's educational experience.

The Federal Family Education Rights and Privacy Act of 1974 permits the school district to release certain information, known as "directory information," to certain people or institutions, unless you request **IN WRITING**, that such information not be released. In many cases, requests for this type of information come from the news media, students, or staff creating web pages or the armed forces for recruiting purposes. "Directory information" may include:

- ✓ Student's name, address and telephone number
- ✓ Date and place of birth
- ✓ Participation in officially recognized activities and sports
- ✓ Weight and height if athletic team member
- ✓ Dates of attendance
- ✓ The most recent educational agency or institution attended by the student
- ✓ Photographs of other similar information
- ✓ In the case of student information in web pages, the following will be excluded: last names, telephone numbers, and addresses.

Pictures may occasionally be taken of students and/or student work for use in web pages, news media or school district publications, as well. We will not release any "directory information" for commercial or other purposes not related to school business.

Special Consent: I authorize my child to be photographed, video taped, or audio taped in connection with the educational program and activities of the Pendleton School District. I understand that my child will not be paid for the photographic image. I also consent to public display of such photograph, video tape, or audio tape image in connection with the Pendleton School District programs and activities.

_____ / _____ / _____
Signature Relationship Date

If you do not wish us to release "directory information" and/or have your child appear in a photograph, videotape, film or slide, please let your school know **IN WRITING** within two weeks of receiving this notice. Otherwise, it is not necessary to take any action.

If you have questions on this notification, please call the Pendleton School District at (541)276-6711

OVER ➡

Physical Address_____City_____Zip _____
Do you live on Trust Land? ❒ YES ❒ NO
Are you living with friends or relatives due to financial hardship? ❒ YES ❒ NO
Is this living situation temporary or due to loss of housing because of financial hardship? ❒ YES ❒ NO

Mailing Address
Street / PO
Box_____City_____Zip_____

Home Phone_____

Other Children Living in Household				
Childs Legal Name (last, first, middle)	Gender	Birthdate	School	Grade
1.				
2.				
3.				
4.				
5.				
6.				

Please attach a separate piece of paper to list additional children.

Parent/Guardian Information (list by priority)

	Name	**Relationship**	**Lives with**	**Phone**	**Cell Phone**	**Employer**
1				Home		
	Email			Work		
2				Home		
	Email			Work		

Emergency Contacts - allowed to pick up student from school

		Relationship				
3			Home Work		Cell	
4			Home Work		Cell	
5			Home Work		Cell	
6			Home Work		Cell	

OFFICIAL USE ONLY:

Enrollment code		**Enrollment date**		**Grade**		**Teacher**	
Records requested		**Records received**		**Immunization status**			
Special Education Teacher Notified		**ELD Teacher Given LUS**		**Homeless Liaison Notified**			

Oregon Certificate of Immunization Status
Oregon Health Authority, Immunization Program

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

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

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

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

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

Signature* _____
Date

Update Signature _____
Date

Update Signature _____
Date

Update Signature _____
Date

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

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

Continued On Reverse Side

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

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

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

For medical exemptions:

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

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

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

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

Nonmedical Exemption:

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

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

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

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

Signature of Parent or Guardian _____ Date _____

Optional:

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

☐ Religious belief ☐ Philosophical belief ☐ Other

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

Signature _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____

Instructions for completing the Certificate of Immunization Status

Contact information:

Complete information for your child including full name, birthdate, current mailing address, parents' or guardians' names and home telephone number. This information will be used to contact you if there are questions about your child's immunization history.

Required vaccines (Front):

Fill in the month/day/year that your child received each dose of vaccine. Doses must be listed in the order received. The shaded boxes on the form indicate doses that are not routinely given, however if your child received them, please write the date in the shaded box. Check with your child's school or daycare to find out which vaccines are required for your child's age or grade.

Recommended vaccines (Back):

These doses are not required by law, however these vaccines are recommended and most children receive them. Fill in the month/day/year that your child received each dose of vaccine. Doses should be listed in the order received. The shaded boxes on the form indicate doses that are not routinely given, however if your child received them, please write the date in the shaded box.

Signature:

The parent or guardian signature is a sworn statement that the child's record is accurate. The signature of a physician or local health department is not required but it is acceptable. **Every time you add on to your child's information you need to resign the form.**

REMEMBER TO COMPLETE BOTH SIDES OF FORM

Exemptions:

Oregon allows medical and nonmedical exemptions.

For a nonmedical exemption, check the appropriate box and submit one of the following required documents:

1. A certificate signed by a health care practitioner verifying discussion of the benefits and risks of immunization, or
2. A certificate of completion of the vaccine educational module about the benefits and risks of immunization.

Indicate which vaccines you are exempting your child from by checking the boxes. Sign and date on the indicated line.

For a medical exemption or proof of immunity, submit a letter from your child's physician to the school or child care.

Instrucciones para llenar el Certificado de Estado de Vacunación

Información de contacto:

Dé la siguiente información sobre su hijo: nombre completo, fecha de nacimiento, dirección postal actual, nombres y números de teléfono de los padres o tutores. Usaremos esta información para comunicarnos con usted si hay preguntas sobre los datos de vacunación de su hijo.

Vacunas requeridas (adelante):

Escriba el mes/día/año en que su hijo recibió cada dosis de vacuna. Las dosis se deben enumerar en el orden en que fueron recibidas. Los casilleros sombreados del formulario indican las dosis que no se dan rutinariamente. Sin embargo, si su hijo las recibió, escriba la fecha en el casillero sombreado. Averiguar con la escuela o guardería cuales son las vacunas requeridas para la edad y grado escolar de su niño.

Vacunas recomendadas (atrás):

Estas dosis no son obligatorias por ley, pero son recomendadas y la mayoría de los niños las reciben. Escriba el mes/día/año en que su hijo recibió cada dosis de vacuna. Las dosis se deben enumerar en el orden en que fueron recibidas. Los casilleros sombreados del formulario indican las dosis que no se dan rutinariamente. Sin embaro, si su hijo las recibió, escriba la fecha en el casillero sombreado.

Firma:

La firma del padre, madre o tutor es una declaración jurada de que la historia de vacunas del niño esta correcta. La firma del médico o del departamento de salud local no son requieridas, pero son aceptable. **Cada vez que agregue datos a la información sobre su hijo debe volver a firmar el formulario.**

RECUERDE LLENAR AMBOS LADOS DEL FORMULARIO

Excepciones:

Oregon permite excepciones médicas y no médicas.

Para una excepción no médica, marque la casilla adecuada y presente uno de los siguientes documentos requeridos:

1. Un certificado firmado por un proveedor de atención de salud verificando la discusión de los beneficios y riesgos de la vacunación, o
2. Un certificado de terminación del módulo educativo de la vacuna sobre los beneficios y riesgos de la vacunación.

Indique para cuáles vacunas quiere que su hijo(a) sea exento(a) al marcar las casillas. Firme y feche la línea indicada.

Para una excepción médica o un comprobante de inmunidad, presente una carta del doctor de su hijo(a) a la escuela o cuidado infantil.

Pendleton School District 16R
Health, Developmental, and Social History
CONFIDENTIAL
For Educational Purposes Only

Student's Name: _____

Parents are: _____Married _____Divorced _____Other (Please Explain) _____

Is there any custodial concerns/parent plan that we should be aware of? _____

_____

_____

DEVELOPMENTAL or EARLY HISTORY:

Did your child meet developmental milestones? _____walk? _____talk? _____toilet trained?

MEDICAL HISTORY and ILLNESS OF STUDENT: (Check those that are true for this child; Star (*) those that are a present concern)

_____ Allergy Known _____Asthma _____Color Blindness _____Concussion _____Diabetes

_____Ear Infections (Tubes in Ears? _____) _____Eye Problems? (Wears Glasses? _____)

_____Hearing Loss (Hearing Aids? _____)

Does the child have any physical limitation/health problems? _____No _____Yes If yes, please describe:

_____

_____

_____

_____

_____

_____

Does this child need special or continuing medical care? _____ No _____ Yes If yes, please describe:

_____

_____

_____

_____

_____

_____

_____

_____

CURRENT GENERAL HEALTH STATUS:

Is child taking any medications? _____ No _____ Yes, for _____

Name of medication: _____ Dosage: _____ Frequency: _____

Is medication needed at school? _____No _____Yes

SOCIAL BEHAVIORS:

Favorite Activities:_____ Home Responsibilities_____

Child behavior/response to anger:_____

Fear/Conflicts: _____

Circle all behaviors that apply to your child: *affectionate; shy, friendly, withdrawn, inactive, curious, hyperactive, impulsive or explosive behavior, cries easily, aggressive, prefers to be alone, easily frustrated.*

Additional comments:_____

_____

_____

_____

_____

Attended Preschool? _____No _____ Yes If yes, how long? _____ Where? _____

Has child been seen by a: _____Psychologist _____ Psychiatrist _____ Counselor

Dates? _____

Comments: _____

_____

_____

_____

_____

ENVIRONMENTAL FACTORS INFLUENCING EDUCATION PROCESS:

How many times has this child moved in the last two years? _____

Has this child experienced death/divorce within the immediate family? _____

Agencies working with the family: _____

What are your educational concerns for this child? _____

_____

_____

_____

_____

Are there other concerns? _____

_____

_____

_____

_____

Parent/Guardian Signature_____ Date _____

Everybody Brush!

CONSENT FOR DENTAL HYGIENE SERVICES

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

Community Location: _____

PATIENT INFORMATION

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

Address / City / State / ZIP: _____

Best phone number to reach you during the day: _____
Friend or family member's phone number to reach you in case you change your phone number: _____

Grade:

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

INITIAL ON YES or NO to receive each service and SIGN and DATE below.

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

List medications currently taking:
_____
_____

☐ Iodine Allergy
☐ Shellfish Allergy (shrimp, crab etc.)
☐ Other Allergies (please list): _____
_____

History of:
☐ Diabetes
☐ Asthma
☐ Tobacco Use
☐ Behavioral Considerations (please describe):
_____

Other (please describe): _____
_____

If you have questions or would like more information about the services provided, please call 1-866-268-9631.

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

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

- I give consent for dental services initialed/indicated above from Advantage Dental Clinics and Advantage Dental Group, PC (jointly "Advantage Dental"), and/or one of its representatives.
- The results of the oral hygiene services, including personal health information and scheduling information, may be shared between Advantage Dental, the dental provider (hygienist or patient's dentist), the community site, any listed insurance carriers, the dentist of record, any applicable Coordinated Care Organization, and/or the Dental Care Organization of record for purpose of treatment, payment or healthcare operations.
- I have been given a copy of the "Notice of Privacy Practices" and HIE (Health Information Exchange) Notification.
- This consent will remain active for 24 months unless revoked in writing or by calling an Advantage Dental representative.

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

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

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

FACT SHEET

Not all services maybe provided at your location

Screening (Teeth Checkup)

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

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

Alternative(s): No checkup.

Fluoride Coating

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

Risk(s): Allergy is not common.

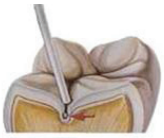
Alternative(s): Daily or weekly fluoride rinses, fluoride foam, or fluoride gels applied at your dentist's office.

Sealant

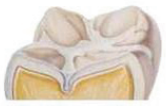
A dental sealant is a white coating put on the chewing surfaces of back teeth where cavities occur most often. Sealants make barriers on teeth that keep bacteria out and prevent cavities. They do not interfere with biting or chewing.

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

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



Before Sealants



After Sealants

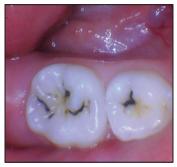
Silver Fluoride

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

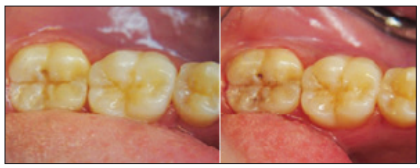
Risk(s): If Silver Fluoride comes in contact with skin it will cause a small dark spot that will go away on its own in 1-2 weeks. If it comes into contact with existing white fillings it might stain.

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

How Silver Fluoride looks on a tooth with a cavity



How Silver Fluoride looks on a tooth with no cavity



Before After

Antiseptic For The Teeth (Iodine)

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

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

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

Protective Restoration

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

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

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

Advantage Dental
From DentaQuest

SUMMARY NOTICE OF PRIVACY POLICY

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

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

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

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

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

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

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

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

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

To Improve the Oral Health of All
www.AdvantageDental.com
442 SW Umatilla Avenue Redmond, OR 97756 | TEL: 866.866.268.9631 | FAX: 866.268.9618

Advantage Dental
From DentaQuest

NON-DISCRIMINATION DISCLOSURE NOTICE

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

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

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

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

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

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

If you would like to request this information in another language or an alternate format such as large print, audio disk, braille, etc. please contact Customer Service at 866-268-9631 or TTY 711.

Language	Translated Statement
English	ATTENTION: If you speak [language], you have services available to you free of charge for language assistance. Call 1-866-268-9631 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-268-9631 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-268-9631 (TTY: 711).
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Everybody Brush! CONSENTIMIENTO PARA SERVICIOS DE HIGIENE DENTAL

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

Localidad Comunitaria: _____

INFORMACIÓN DEL PACIENTE

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

Dirección / Ciudad / Estado / Codigo Postal: _____

Mejor número de teléfono para comunicarnos con usted durante el día: _____
Numero de teléfono de un amigo o pariente para comunicarnos con usted en caso de que cambie su número de teléfono:
_____

Grado:

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

ANOTE SUS INICIALES EN SI o NO para recibir cada servicio y FIRME Y FECHE abajo.

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

Lista de medicamentos que está tomando actualmente:
_____
_____

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

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

Otro (por favor describa): _____
_____

Si tiene preguntas o le gustaría más información acerca de los servicios provistos, por favor llame al 1-866-268-9631.

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

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

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

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

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

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

HOJA INFORMATIVA

Pueda ser que no todos los servicios sean disponibles en su sitio

Evaluación (Chequeo de dientes)

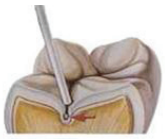
Un profesional de cuidado dental mirara dentro de la boca para revisar si existen cambios en los dientes que podrían indicar caries u otros problemas de salud oral.
Riesgo(s): Carie u otros problemas podrían existir y empeorar si no son descubiertos.
Alternativa(s): No hacer el chequeo.

Capa de Fluoruro

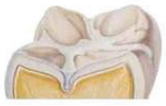
Un capa delgada temporaria (también llamado barniz) aplicada a los dientes para ayudar a proteger contra caries. La capa es segura aun si es ingerida. Esta no perjudica ni mancha los dientes.
Riesgo(s): Una alergia no es común.
Alternativa(s): Enjuagues bucales de fluoruro diario o semanal, espuma de fluoruro, o gel de fluoruro aplicado en la oficina de su dentista.

Sellador

Un sellador dental es una capa blanca aplicada a las superficies de masticación de los dientes de atrás donde las caries suelen ocurrir más frecuentemente. Los selladores forman una barrera en los dientes que mantiene fuera a la bacteria y previene las caries. Estos no interfieren con el morder o el masticar.
Riesgo(s): Los selladores solo protegen las superficies de masticación. Pueden durar varios años, pero algunas veces necesitan ser reemplazados.
Alternativa(s): Fluoruro de Plata. No selladores. El elegir no utilizar selladores puede incrementar las posibilidades de desarrollar caries en las superficies de masticación de los dientes.



Antes de selladores

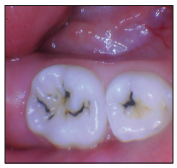


Despues de selladores

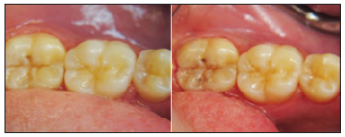
Fluoruro de Plata

FEl fluoruro con plata se ve como agua. Este es pintado en los dientes con un cepillo pequeño y puede sanar la carie dental precoz. Se aplica rápido, y no duele. Si existen caries en la boca, el fluoruro de plata puede prevenir el que crezca, y algunas veces hasta las sana. Las caries que son detenidas o sanadas con fluoruro de plata se tornaran café oscuro o negras. Los dientes sin caries no cambiaran de color. Si el color se enseña mucho, un profesional dental puede cubrirlo con material para un relleno blanco. Rellenos quizá no sean necesarios para las caries que han sanado con fluoruro de plata.
Riesgo(s): Si el fluoruro de plata se pone en contacto con la piel causara una pequeña mancha oscura que desaparecerá por sí misma en 1-2 semanas. Si se pone en contacto con rellenos blancos existentes quizá se manchen.
Alternativa(s): No aplicar fluoruro de plata. Esto podría dejar bacteria dañina en sus dientes e incrementar la posibilidad de caries dental. Utilizar una pasta dental con fluoruro regularmente y obtener aplicación de barniz de fluoruro y selladores en la oficina de su dentista.

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



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



Antes Después

Antiséptico para los dientes (Yodo)

El antiséptico mata la bacteria que causa caries. Cuando es aplicada antes de una capa de fluoruro, previene muchas más caries que la capa de fluoruro por si sola. El yodo es una parte normal de nuestra dieta de comida y es seguro. Este no daña o mancha los dientes.
Riesgo(s): Reacciones alérgicas no son comunes, pero no debería de recibir este tratamiento si es alérgico a los mariscos.
Alternativa(s): No aplicar yodo. Esto podría dejar bacteria dañina en sus dientes e incrementar la posibilidad de caries dental.

Restauración Protectora

Este es un simple relleno del color del diente aplicado en la carie para proteger el diente hasta que se pueda aplicar un relleno permanente. Aliviar el dolor y ayuda a sanar dentro del diente. No se necesitan inyecciones. No duele.
Riesgo(s): Las restauraciones protectoras podrían parcialmente caerse, pero lo que permanezca seguirá protegiendo el diente.
Alternativa(s): Un relleno o capa regular. Sin cuidado, la carie podría crecer y hacerse dolorosa.

Advantage Dental
From DentaQuest

RESUMEN DE AVISO DE PRACTICAS DE PRIVACIDAD

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

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

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

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

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

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

To Improve the Oral Health of All
www.AdvantageDental.com
442 SW Umatilla Avenue Redmond, OR 97756 | TEL: 866.866.268.9631 | FAX: 866.268.9618

Advantage Dental
From DentaQuest

Divulgación de Póliza Antidiscriminatoria

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

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

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

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

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

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

Comuníquese con esta oficina mediante una de las siguientes maneras:

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

Si le gustaría solicitar esta información en otro lenguaje o un formato alternativo tal como letra grande, disco audio, braille, etc. por favor comuníquese con Servicios al Miembro al 866-268-9631 o TTY 711.

Language	Translated Statement
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Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-866-268-9631 (TTY: 711).

State of Oregon Language Use Survey

The 2020-21 Language Use Survey (LUS) is under development. Until the 2020-21 version is finalized, districts may choose to use either of the Language Use Surveys available on the ODE website.

This form is given to all students entering into a school district for the first time.

The purpose of the **Language Use Survey** is to help the school determine if your child qualifies for additional **Title III** supports in language instruction for English learners.

Title III provides support for English learners as defined by USED.

The State of Oregon honors the language and culture of its people and respects the over 166 languages in our schools, and recognizes that:

- Language is a key component of each person's cultural identity,
- Heritage and primary languages are instrumental in student academic and cultural success, and
- Students who are multilingual/multicultural may have an advantage over students with a single language and are valued in career placements.

Student Name: _____ **Grade:** _____ **Date:** _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Descriptions	Questions
Communication Preferences This question helps the school provide an interpreter or translated documents, free of charge, should you want them. ***This section is for informational purposes only.*** *It is not used to identify your child for English language proficiency placement testing.*	1. What language(s) would you prefer the school use to communicate with you? _____
Eligibility for Language Development Support This section helps the school identify if your child should be assessed to receive support in academic English instruction. ***This section is used to identify your child for English Language Proficiency placement testing.*** *A response other than English to questions #2, #3, and/or #4 may qualify your child for English language proficiency placement testing.*	2. What is the primary language(s) used to communicate in your home? _____ 3. What language(s) did your child learn first? _____ 4. What language(s) is most often used by your child at home? _____

State of Oregon Language Use Survey

The 2020-21 Language Use Survey (LUS) is under development. Until the 2020-21 version is finalized, districts may choose to use either of the Language Use Surveys available on the ODE website.

Below is the United States Department of Education definition of an English learner.

The term "English learner," when used with respect to an individual, means an individual —

(A) who is aged 3 through 21;

(B) who is enrolled or preparing to enroll in an elementary school or secondary school;

(C) (i) who was not born in the United States or whose native language is a language other than English;

(ii) (I) who is a Native American or Alaska Native, or a native resident of the outlying areas; and

(II) who comes from an environment where a language other than English has had a significant impact on the individual's level of English language proficiency; or

(iii) who is migratory, whose native language is a language other than English, and who comes from an environment where a language other than English is dominant; and

(D) whose difficulties in speaking, reading, writing, or understanding the English language may be sufficient to deny the individual —

(i) the ability to meet the challenging State academic standards;

(ii) the ability to successfully achieve in classrooms where the language of instruction is English; or

(iii) the opportunity to participate fully in society.

(ESEA Section 8101(20))

Race and Ethnicity Form

Legal Name: _____
Last *First* *Middle*

Preferred Name: _____
Last *First* *Middle*

Date of Birth:_____/_____/_____ Student Number: _____

If an individual or the parent on behalf of the student does not complete the two-part question, then the educational institution will take steps to collect and document information allowing the reporting of the individual in one of the Federal reporting categories. The US Department of Education will continue its existing policy of ***using observer identification in these cases.***

Ethnicity: *(Choose one)*

☐ **Hispanic/Latino**
(A Hispanic or Latino person is of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

☐ **Not Hispanic/Latino**

Race: *(Choose one or more, regardless of Ethnicity)*

☐ **American Indian or Alaskan Native** *(An American Indian or Alaska Native person has origins in any of the original peoples of North and South America (including Central America)*

☐ **Asian** *(An Asian person has 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.)*

☐ **Native Hawaiian or Other Pacific Islander** *(A Native Hawaiian or Other Pacific Islander person has origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)*

☐ **Black or African American** *(A Black or African American person has origins in any of the black racial groups of Africa.)*

☐ **White** *(A White person has origins in any of the original peoples of Europe, the Middle East, or North Africa.)*

OMB, Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, 62 FR 58782–58790

Signature: _____
Parent/Guardian *Date*

Formulario de Etnicidad y Raza

Nombre legal: _____
Apellido *Primero* *Segundo*

Nombre Preferido: _____
Apellido *Primero* *Segundo*

Fecha de Nacimiento:_____/_____/_____ Número Estudiantil: _____

Si un individual o el padre departe del estudiante no llena el cuestionario de dos partes, entonces le institución de educación tomará los pasos y documentará la información permitiendo el informe del individuo en unas de las categorías del informe federal. El Departamento de Educación continuará su póliza existente ***de usar observadores identificadores en estos casos****.*

Etnicidad: *(escoja uno)*

☐ **Hispano/Latino**
(Una persona Hispana o Latina es Cubano, Mexicano, Puertorriqueño, Sur o Centroamericano, o otra cultura o origen Español, a pesar de raza)

☐ **No Hispano/Latino**

Raza: (*Escoja uno o más a pesar de la Etnicidad)*

☐ **Nativo Americanos o Nativo de Alaska** *(Una persona Nativo Americano o Nativo de Alaska tiene orígenes de cualquier habitante original del Norte y Sur de América (incluyendo Centroamérica)*

☐ **Asiático** *(Una persona Asiático tiene orígenes de cualquier habitante original del Extremo Oriente, Sudeste Asiático de indígenas subcontinente, incluyendo, por ejemplo, Camboya, China, Indio, Japón, Corea, Malasia, Pakistán, Las islas Filipinas, Tailandia y Vietnam.)*

☐ **Nativo Hawaiano o Otro Isleño del Pacifico** *(Una persona Nativo Hawaiano o Otro Isleño del Pacifico tiene origines de cualquier habitante original de Hawái, Guam, Samoa, u otro Isleño Pacifico.)*

☐ **Negro o Africano Americano** *(Una persona Negra o Africano Americano tiene orígenes en cualquier grupo racial negro de África.)*

☐ **Raza blanca** *(Una persona blanca tiene origines de cualquier habitante original de Europa, el Medio Oriente, o África del Norte.)*

OMB, Revisiones al Estándar para la Clasificación de Datos Federal en Raza y Etnicidad, 62 FR 58782–58790

Firma: _____
Padre/Tutor *Fecha*

Pendleton School District 16R
Computer Technology
Student Acceptable Use Policy for PSD Net

Computers and access to the internet are used to support learning and to enhance instruction. With parental permission, your student will have an email account and internet access through the Pendleton School District's computer system (PSDnet).

While utilizing the internet it is possible to gain access to information which may not be appropriate. It is a general policy that all computers used through PSDnet are to be used in a responsible, appropriate, efficient, ethical and legal manner. Failure to adhere to the policy and the guidelines for the use of PSDnet, as described below, will result in the immediate revocation of access privileges as well as possible disciplinary action, and/or referral to law enforcement. Reinstatement will be at the discretion of the school administration.

GENERAL USE PROHIBITIONS

1. Prohibitions
    a. Attempts to degrade, disrupt or vandalize the district equipment, software, materials or data or those of any other system or user
    b. Attempts to send, intentionally access or download any text file or image or engage in communication that includes material which may be interpreted as:
        i. Harmful to minors
        ii. Obscene, indecent, profane or lewd as determined by the district
        iii. A product or service not permitted to minors by law
        iv. Harassment, bullying, intimidation, menacing, threatening or insulting and/or inflammatory language
        v. A likelihood that, either because of its content or the manner of distribution, it will cause a material or substantial disruption of the school operation
    c. Attempts to use another individual's account, failure to provide the district with individual passwords or to access restricted information, resources or networks to which the user has not been given access.
2. Violations/Consequences
    a. Students who violate general system user prohibitions shall be subject to discipline up to and including expulsion and/or revocation of district system access up to and including permanent loss of privileges
    b. Violations of law will be reported to law enforcement immediately

I have read the district's acceptable use policy pertaining to student internet usage. I give permission for my student to participate and utilize the Pendleton School District's computer system.

Student Name _____

Name of Parent/Guardian _____

Parent/Guardian Signature _____

Pendleton School District Policies
http://policy.osba.org/pendletn/search.asp?target=electronic+use
http://policy.osba.org/pendletn/j/jfcfa_gbnaa%20g1.pdf
http://policy.osba.org/pendletn/i/iibga%20d1.pdf
http://policy.osba.org/pendletn/i/iibga%20r%20d1.pdf

107 NW 10th St.
Pendleton, OR 97801
Ph: 541-276-6711
Fax: 541-278-3208
www.pendleton.k12.or.us
Chris Fritsch-Superintendent

SPECIAL NEEDS CHILD FIND

Pendleton School District actively identifies individuals with disabilities under the age of twenty-one (21). For children under the age of five (5) screening, evaluation, diagnosis and programming is available through the InterMountain Education Service District (541-276-6616).

Pendleton School District provides for evaluation, diagnosis, and specialized educational programming for school age children (ages 5-21). The following special education services are provided:

1. Special education and related services appropriate to their needs for students who are eligible for services under the following disability categories: Specific Learning Disability, Communication Disorder, Visual Impairment, Hearing Impairment, Orthopedic Impairment, Autism, Other Health Impairment, Emotional Disturbance, Intellectual Disability, or Traumatic Brain Injury.
2. Evaluations and planning for eligible students under Section 504 of the Rehabilitative Act of 1973.

For more information contact:
Julie Smith
Special Programs Director
Pendleton School District
107 NW 10th St.
Pendleton, OR 97801
541-966-3262

MID-COLUMBIA BUS COMPANY, INC.

Phone 541-276-5621

Dear Parents,

The below information is required for each student riding a school bus to determine eligibility, planning of bus loads and possible route revisions. This card must be completed and returned to the bus company with any special information concerning the students, before riding the bus. This information is needed to ensure a safe ride to and from school for the student.

PLEASE PRINT

Student Name _____

Resident Address _____

Name of Parent or Guardian _____

School _____ Grade _____

Phone Numbers

Home _____ Work _____

I UNDERSTAND REGULATIONS GOVERNING STUDENT CONDUCT ON SCHOOL BUS AS INDICATED ON THE REVERSE SIDE, AND HAVE EXPLAINED THEM TO THE ABOVE STUDENT.

_____ _____

Date Signature of Parent or Guardian

Notes or Information

_____

_____

_____

- - - - - - - - - - - - - - - -

MY CHILD WILL RIDE THE BUS:

☐ **To school**

☐ **Home from school**

☐ **Not at all**

KINDERGARTEN STUDENTS MUST BE PICKED UP BY AN 18 YEAR OR OLDER ADULT.

RULES GOVERNING PUPILS RIDING SCHOOL BUSES

OAR 581-53-010

(1) Pupils being transported are under authority of the bus driver.

(2) Fighting, wrestling, or boisterous activity is prohibited on the bus.

(3) Pupils shall use the emergency door only in case of emergency.

(4) Pupils shall be on time for the bus both morning and evening.

(5) Pupils shall not bring animals, firearms, weapons, or other potentially hazardous material on the bus.

(6) Pupils shall remain seated while bus is in motion.

(7) Pupils may be assigned seats by the bus driver.

(8) When necessary to cross the road, pupils shall cross in front of the bus or as instructed by the bus driver.

(9) Pupils shall not extend their hands, arms, or heads through bus windows.

(10) Pupils shall have written permission to leave the bus other than at home or school.

(11) Pupils shall converse in normal tones; loud or vulgar language is prohibited.

(12) Pupils shall not open or close windows without permission of driver.

(13) Pupils shall keep the bus clean, and must refrain from damaging it.

(14) Pupils shall be courteous to the driver, to fellow pupils, and passersby.

(15) Pupils who refuse to obey promptly the directions of the driver, or refuse to obey regulations, may forfeit their privilege to ride on the buses.

(16) Rules Governing Pupils Riding School Buses must be kept posted in a conspicuous place in all school buses.