Second Mesa Day School
P.O. Box 98
Second Mesa, AZ 86043
Phone: (928)737-2571 Fax: (928)737-2565
Home of the Mighty Bobcats
"ITAH TSATSAYOM MOPEKYA"

June 27, 2023

Greetings Parents, Guardians, and Community Members:

Time is quickly passing, and we will soon be starting school once again! In preparation for the upcoming school year, we are continuing to advertise for teachers; however, we have had little inquiries. Recruitment has been on-going with a visit to the AZ State Department of Education annual recruitment fair that was held in March. Many school districts, charter schools, and reservation schools were on-site; ironically, a low teacher response left many schools remaining with unfilled positions including Second Mesa Day School. As you are aware, there is a national teacher shortage in America!

Fortunately, we do have enough certified teachers currently on-board to fill our teacher positions for each grade level. With the limited amount of certified teachers, we will be capping enrollment this year with 25 students per grade level. Please note the following:

Kindergarten – 1 class @ 25 students

First Grade – 1 class @ 25 students

Second Grade – 1 class @ 25 students

Third Grade – 1 class @ 25 students

Fourth Grade - 1 class @ 25 students

Fifth Grade - 1 class @ 25 students

Sixth Grade – 2 classes @ 25 students

Understand that classes may change should we receive teacher applicants. In the meantime, enrollment will be based on a first come first served basis. Students outside of the SMDS boundary are still eligible to attend school at SMDS as the waiver will not take effect this academic school year.

With the capped enrollment and one teacher per grade level, except for sixth grade, I encourage you to submit your student's application in a timely manner and ensure all required documents are submitted. Once a grade level has met its maximum number of enrollees, students will be placed on a waiting list and/or recommended to attend a local elementary school.

To expedite the process of your student's enrollment application, begin scheduling your physical appointments, update immunizations, attain CIB documents from tribal office where enrolled or awaiting enrollment, and complete parent/guardian affidavit if student is not residing with legal parent but with identified guardian. These important documents hinder the process of enrolling students.

At SMDS, we continue to find solutions for the teacher shortage, however, it is not an easy process as it requires continued educational college hours. I encourage you as stakeholders to assist us in recruiting teachers as well by referencing them to us!

We look forward to a new school year and our continuation of collaboration with our partners in learning!

If you have any questions, please feel free to contact the school and speak to the registrar, Mrs. Lomakema or myself, Mrs. Thomas.

Askwali,

Kimberly K. Thomas
Principal

P.O. Box 98
Second Mesa, Arizona 86043
(928) 737-2571 / Fax (928) 737-2565

RETURNING STUDENT
Registration Checklist

SCHOOL YEAR 2022-2023

Student Name:_____ **Grade:**_____

Check List of Required documents/forms, to be officially registered.
(PLEASE MAKE SURE ALL FORMS ARE SIGNED BY PARENT AND/OR GUARDIAN WHERE NECESSARY.

_____ *Student Enrollment Application (1 pages)*

_____ *Parental Consent Form (1 page)*

_____ *Student Check-Out/Transportation Form (1 page)*

_____ *Medical Attention Form (1 pages)*

_____ *Student Health History-Part I & II (2 pages)*

_____ *Library Permission Form (1 page)*

_____ *HHCC Dental Screening Form (1 page)*

_____ *HHCC Influenza Vaccination Form (1 page)*

_____ *Home Language Survey Form (1 page)*

_____ *Technology Consent Form (1 Page)*

_____ *PE Participation Forms (3 Pages)*

_____ *Physical Examination Form (4 Pages)*

_____ *McKinney-Vento Form (1 Page)*

** ***These items are mandatory at time of enrollment. Student will NOT start school if documents are not on file. Please check with Registrar.***

_____ *Guardian Affidavit – if applicable (1 page)*

_____ *Updated Immunization Record* ***(Mandatory)***

This Section For Office Use Only

RECEIVED BY:_____ DATE:_____
COMPLETE_____ PENDING_____ NOTE:_____

_____

CSA/PRINCIPAL SIGNATURE:_____

☐ **APPROVED DATE:**_____ ☐ **DISAPPROVED DATE:**_____

Entry Date:_____ **Enrollment Code:**_____ **Enrollment #:**_____

Teacher Placement:_____ **Grade:**_____

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SY 2023 - 2024

** Returning Student **
Enrollment Application

Student Identification:

Student Full Name: _____ Grade Applying_____

Mailing Address (PO Box, City, State, Zip) _____

Home Physical Address: _____

Community/Village student resides in: _____

PRIMARY PARENT OR LEGAL GUARDIAN INFORMATION (With whom student lives with)

With whom does student live with: If other than father / mother, please provide guardianship documentation?

Mother: ☐ **Father** ☐ **Both Parents** ☐ **Grandparents** ☐ **Guardian** ☐

Other ☐ **(Specify)** _____

PRIMARY #1: Parent / Legal Guardian Information	PRIMARY #2: Parent / Legal Guardian Information
1. NAME: _____	1. NAME: _____
2. Relationship to Student: _____	2. Relationship to Student: _____
3. Home#: _____	3. Home#: _____
4. Cell#: _____	4. Cell#: _____
5. Work#: _____	5. Work#: _____
6. Message #: _____	6. Message #: _____
7. Email: _____	7. Email: _____

IS STUDENT CURRENTLY UNDER GUARDIANSHIP? ☐ **YES** ☐ **NO**

If "YES" Does parent/s have any visitation rights: Mother: ☐ **YES** ☐ **NO** **Father:** ☐ **YES** ☐ **NO**
(Please provide legal documentation)

In cases where custody/visitation affects the school, the school shall follow the most recent court order on file with the school. It is the responsibility of the custodial parent or parents having joint custody to provide the school with the most recent court order.

I (Parent/Guardian) am legally responsible for this student and hereby apply for his/her admission to this school. I understand that additional information may be requested by the school before the student is officially enrolled.

_____ **Date** _____

Signature of Parent/Legal Guardian

SECOND MESA DAY SCHOOL
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PARENTAL CONSENT FORM
FIELD TRIPS AND SPORTS

Student Name: _____

I (We) hereby grant permission for my/our child to participate in an organized school sponsored activity trip as approved.
I (We) understand the students will be properly chaperoned and all precautions will be taken to insure his/her safety.
(NOTE TO PARENTS: Permission slips will be sent home prior to field trips.

(CHECK ONLY THOSE APPROPRIATE)

FIELD TRIPS

☐ Recreational ☐ Overnight Trips ☐ On Reservation ☐ School Clubs
☐ Off Reservation ☐ Camping ☐ Out of State ☐ Extra Curricular

****

I (We) hereby grant consent/permission/authorization for the following (*Parents will be notified, if the following should occur)*

☐ Transport student to medical facilities:
☐ Hospital/Clinic to provide student with health services.
☐ Emergency Medical Care

Comments: _____

****

I (We) hereby grant consent/permission/authorization for student to participate in the following competitive sports: (All sports participations will require a Physical Examination before student can participate)

☐ Basketball ☐ Softball ☐ Swimming ☐ Cross Country ☐ Soccer
☐ Cheerleading ☐ Volleyball ☐ Flag Football ☐ Chess

Signature of Parent/Legal Guardian: _____ Date _____

SY 2023 - 2024
STUDENT CHECK-OUT/
BUS TRANSPORTATION

Student Name: _____ GRADE: _____

I (We) Parents/Guardians give authorization for the following listed individuals (below) to **CHECK-OUT** my/our child from school and/or **RECEIVE** them from the bus after school.

Parent/Guardian Name: (*Please Print*) _____

Parent/Guardian Phone Contact: _____

Please PRINT names clearly and list each individual separately (not as "Mr. & Mrs.")

	Name of Individual	Relationship to Student	Phone Contact
1.			
2.			
3.			
4.			
5.			

Bus Transportation Arrangement:

Primary Pick-up location: _____

Primary Drop-off location: _____

PLEASE READ & INITIAL

* _____ Pick-Up & Drop-Off destination points will be scheduled as closest to student's residence. During bad weather months when off road/dirt roads get muddy– buses WILL NOT transport students on dirt roads. (Parents/Guardians will need to drop-off/pick-up students on paved roads).

* _____ Parents/Guardians – PLEASE…have your children utilize the primary arrangements – This will eliminate the overcrowding of buses and mix-ups with destination points. Unless there is an urgent or emergency need for alternate arrangement.

* _____ If student will be picked up or dropped-off at an alternative site due to **URGENT** or **EMERGENCY** situations, a written note is required from the primary as listed on the registration specifying the location and signed by the authorized parent or guardian. ***ALL NOTIFICATIONS NEED TO BE TURNED INTO THE OFFICE BY 12:00 PM - NO LATER.***

Parent/Guardian Signature _____ Date _____

SY 2023 - 2024
Medical Attention Form

Student Name: _____ **GRADE:** _____

Second Mesa Day School provides a health care program for all our students. Clinical care will be provided during preset clinic hours by qualified and authorized medical personnel in the nurse's station. Parents/Guardians must take students to the hospital/clinic for care during times when the nurse's station is not staffed by the medical personnel.

The Nurse's Station at Second Mesa Day School will include the following:

1. **EMERGENCY MEDICAL CARE** for accidents or serious illnesses occurring during school hours. When necessary, the student will be transported to the Hopi Health Care Center.
2. **ROUTINE HEALTH CARE,** including preventive health screening and health counseling. Available services may include immunizations, care for common adolescent physical concerns, drug and alcohol assessment and counseling. Dental care including sealants and preventive use of fluorides.
3. **CARE FOR NON-EMERGENT ILLNESSES,** including antibiotics and indicated medical prescriptions.
4. **IMMUNIZATIONS,** State Law require that **ALL** school age children **MUST** have current immunization records on file to be enrolled or to attend school. Please bring your child's immunization record with you during the enrollment process so the school can make a copy. (Please refer to the Arizona School Immunization Law for more information)
5. **VISION, HEARING AND SCOLIOSIS SCREENING** of selected students (in accordance with state regulations) and any student requesting an examination.
6. **SPORTS PHYSICALS** - Students who will be participating in any sports activities during the school year 2023-2024 **MUST** have a physical done prior to start of any sport activities. Forms are available on the school website and at the school office. These physicals are good for one (1) year. It is best to try and schedule these physical appointments during the summer months to avoid delay in student's sports participation.

All medical records will be kept confidential. No medical information will be shared between medical staff and school personnel. No elective procedures will be performed without parental permission. Student will be guaranteed confidential care in accordance with Arizona State Law.

I (We) fully understand all statements/guidelines indicated above and hereby grant permission for my child to receive full school services as described above while attending Second Mesa Day School.

☐ I hereby give consent for all of the services listed above.

☐ Exceptions or Special Instructions: _____

_____

In case of emergency, please provide emergency contact names and phone numbers of at least 3-4 names. Individuals must not have the same phone number. (Phone numbers must be current and working number at all times)

NAME: _____ **Phone#:** _____

NAME: _____ **Phone#:** _____

NAME: _____ **Phone#:** _____

NAME: _____ **Phone#:** _____

Parent/Guardian Signature: _____ **Date:** _____

Valid Until: June 30, 2024

SECOND MESA DAY SCHOOL
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SY 2023 - 2024
Student Health History
Part I

Student Name: _____ GRADE: _____

Parent/Guardian Name: _____ Relationship to Student: _____

Name of Family Physician/Dentist if other than PHS/IHS: _____

Family Physician/Dentist Phone #: _____

Please indicate the change in your child's health and date:

IF NO CHANGE FROM LAST YEAR – CHECK BOX / SIGN AT BOTTOM AND GO TO NEXT PAGE. ☐

	Yes	No	Date		Yes	No	Date
ANEMIA	☐	☐	_____	TUBERCULOSIS	☐	☐	_____
ARTHRITIS	☐	☐	_____	JOINT PAINS	☐	☐	_____
ASTHMA	☐	☐	_____	KIDNEY TROUBLE	☐	☐	_____
HEPATITIS	☐	☐	_____	SORE THROATS	☐	☐	_____
SEIZURES	☐	☐	_____	BACK PROBLEMS	☐	☐	_____
MIGRANE HEAD ACHES	☐	☐	_____	SPINAL INJURIES	☐	☐	_____
BRAIN INJURY	☐	☐	_____	DIABETES	☐	☐	_____
HEART PROBLEMS	☐	☐	_____				

Does your child wear prescriptive glasses: ☐ YES ☐ NO If "YES" indicate at what AGE: _____

Has your child had any surgery or operations: ☐ YES ☐ NO (If "Yes" please explain) _____

Has your child had any sprains or fractures? ☐ YES ☐ NO (If "Yes" please explain) _____

Is your child allergic to any medication? ☐ YES ☐ NO (If "Yes" please explain) _____

Does your child have any allergic reactions to certain foods or insect bites/stings? ☐ YES ☐ NO _____

Does your child use and asthma inhaler of any type? ☐ YES ☐ NO (If "Yes" please explain) _____

Has your child been diagnosed by Physician with ADHD? ☐ YES ☐ NO If "YES" Date Diagnosed: _____

List any other health concern not listed above: _____

Parent/Guardian Signature: _____ **Date:** _____

Student Name: _____ GRADE: _____

Administering Medicine To Students
Part II

Medications may be administered to your child/children if you follow these simple guidelines:

1. The medication must be in its original container as prepared by a Pharmacist and labeled with patients name with all directions, dosage compound contents and proportions clearly marked.
2. A parental permission form must be signed and on file.
3. All medications are to be given to the Medical Technician to be stored where it will be marked with the student's name and kept in a locked cabinet. Any medication remaining will be returned to the student at the end of the school year.

** Student's will not self-administer medication at school due to possible over dosage, and/or hinder complications. A SIGNED PHYSICIAN'S STATEMENT INDICATING THE NECESSITY MUST ACCOMPANY ANY REQUEST FOR SELF-ADMINISTERING OF PRESCRIBED MEDICATION.

PRESCRIBED MEDICATIONS

Is your child currently taking prescribed medications: ☐ Yes ☐ No (If "NO" PLEASE SIGN and go to next page)

Type of Medication: _____

Diagnosis/reason for giving medication: _____

_____

Times medication is given: _____

Date: From _____ To: _____

Hospital Name/City/State: _____

_____

Physician's Name: _____

Thank you for completing this Health History. This will become part of your child's health record. Please let the schools know as soon as possible if there are any changes to the information you provided.

Parent/Guardian Signature: _____ **Date:** _____

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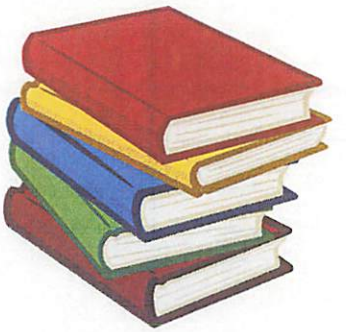
Dear Parents/Guardians,

This letter is to inform you of the policy for the Second Mesa Day School Library books check out system.

1. Students will be coming to the Library once a week to check out books and other materials.
2. These items will be due back in the Library in one week.
3. It is expected that the items be returned in the same condition as when they were checked out.
4. If any items are lost or damaged, you as parents/ guardians will be responsible for the cost of the item.
5. All students must return Library materials on the date they are due.



In addition to checking out books, the students will be learning Library skills, Library manners, and be introduced to the pleasure of reading. We hope that these experiences will prove enriching and develop lifelong reading appreciation.

We encourage all students to participate as library readers. Do all you can to encourage your child to read.

Thank You,

Librarian

Second Mesa Day School Policy

I (we) hereby grant consent/permission/authorization for my child to participate in the school Library check out system and agree to abide by the above set policies for SY 2023-2024.

Student Name:_____GRADE: _____

Parent/Guardian (Please print):_____

Parent/Guardian Signature:_____ **Date:**_____

Office Use – Only

*Student Enrollment Date:*_____*Student ID#*_____

*Assigned Teacher:*_____

2023 Hopi Health Care Center School-Based Dental Disease Prevention Program

Name of Child: _____ Date of Birth: _____ Grade_____

The **IHS Hopi Health Care Center Dental Clinic** is excited to restart our school based outreach program with the intention of **screening for and preventing dental disease** (cavities). A licensed Indian Health Service doctor will be on site at all times to oversee all activities. This screening **DOES NOT** take the place of regular dental visits. For any further questions please call 928-737-6162.

Please Circle One of the Following:

YES - I am the legal caregiver and give my consent for the school-based dental screening program.

Or

NO - I do not want my child to participate in any school based dental outreach programs.

If NO, who is the child's regular dental provider: _____

The following preventive treatment MAY be provided as determined by the dentist on site:

- Dental Screening / Examination
- X-rays (as determined by dentist)
- Dental cleaning
- Dental Sealants (Small preventive fillings that do not require drilling into the tooth)
- Fluoride Varnish (for prevention of cavities)
- Oral Hygiene Instruction (teaching about how to clean your teeth)

In urgent situations involving severe pain, infection, or trauma, EVERY ATTEMPT WILL BE MADE TO CONTACT THE CAREGIVER AT THE NUMBER BELOW prior to providing dental services.

_____ _____

Signature Relationship to Student

_____ _____

Date Contact Phone

Notes:_____

_____

_____

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Hopi Health Care Center
P.O. Box 4000
Highway 264, MM 388
Polacca, Arizona 86042

Influenza Vaccination Clinic
2023-2024 PARENTAL CONSENT FORM

****Regular Seasonal Flu ****

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT INFORMATION		
Last Name	First Name	Middle Initial
STUDENT'S DATE OF BIRTH Month: Day: Year:	HHCC Chart # Yes or No	STUDENT'S GENDER Male or Female
PARENT/LEGAL GUARDIAN		
Last Name	First Name	Middle Initial

***** If this is the FIRST time your child (8 years old and younger) is receiving the Influenza vaccine, she/he is required to return to clinic for a booster in 4 weeks. Parent(s)/guardian(s) must make this arrangement. *****

The following questions will help us know if your child can get the 2023-2024 Influenza vaccine.

Section 2: Child Health History

	YES	NO
1. Does your child have a serious allergy to eggs?		
2. Does your child have any other serious allergies that you know of? If so, please list:		
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?		
4. Has your child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
5. Does your child have any chronic illnesses such as **asthma, seizures, heart disease**, or other **medical conditions** that require frequent doctor visits and medications? **If you indicate *YES*, your child will receive a shot.**		

Section 3: Consent for Vaccination

☐ **I GIVE CONSENT:** I have read and understand the VIS on Inactivated Influenza Vaccine.

☐ **I DECLINE:**

_____ _____
Signature of Parent / Legal Guardian Date

_____
Phone Number

Please return to your child's school as soon as possible.

For more information about the 2023-2024 Seasonal Influenza vaccine, please call the Hopi Health Care Center at (928) 737-6257.

State of Arizona
Department of Education
Office of English Language Acquisition Services

Primary Home Language Other Than English (PHLOTE)
Home Language Survey

(Effective April 4, 2011)

These questions are in compliance with Arizona Administrative Code, R7-2-306(b) (1), (2), (a-c)

Responses to these statements will be used to determine whether the student will be assessed for English Language Proficiency.

1. What is the primary language used in the home regardless of the language spoken by the student?

   _____

2. What is the language most often spoken by the student? _____

3. What is the language that the student first acquired? _____

Student Name: _____ Student ID _____

Date of Birth: _____ SAIS ID _____

Parent/Guardian Signature _____ Date _____

District or Charter _____

School _____

Please provide a copy of the Home Language Survey to the ELL Coordinator/Main Contact on site.

In SAIS, please indicate the student's home or primary language.

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STUDENT USAGE AGREEMENT

1. I WILL USE THE INTERNET ONLY FOR SCHOOL PURPOSES.
2. I WILL USE THE INTERNET FOR LEARNING OR RESEARCH APPROVED BY A TEACHER.
3. I WILL RESPECT THE PRIVACY OF OTHER COMPUTER USERS AND WILL NOT OPEN, CHANGE OR REMOVE ANYONE ELSE'S FILES OR WORK.
4. I WILL ALWAYS USE APPROPRIATE LANGUAGE WHEN WRITING OR COMMUNICATING ON THE INTERNET.
5. I WILL NOT GIVE MY NAME, ADDRESS, SCHOOL OR TELEPHONE NUMBER TO ANYONE ON THE INTERNET.
6. I WILL NOT TAKE ANY MATERIAL THAT I COPY FROM THE INTERNET AS MY OWN. IF I COPY ANYTHING FROM THE INTERNET FOR MY SCHOOL ASSIGNMENTS, I WILL GIVE CREDIT TO THE AUTHOR.
7. I WILL FOLLOW THE INTRUCTIONS OF MY TEACHER, TEACHER ASSISTANTS, LIBRARY AND COMPUTER LAB STAFF OR OTHER SCHOOL EMPLOYEES WITH RESPECT TO USING COMPUTERS, SOFTWARE OR THE SMDS NETWORK.
8. I WILL RESPECT AND SHOW PROPER CARE AND HANDLING OF ALL EQUIPMENT.
9. I WILL NOT WASTE PAPER AND INK BY PRINTING THINGS I DO NOT NEED FOR MY SCHOOL WORK.
10. I WILL NOT HARM OR DESTROY ANY EQUIPMENT OR INFORMATION ON PURPOSE.
11. I WILL NOT CHANGE ANY SETTINGS ON ANY SCHOOL COMPUTERS WITHOUT PERMISSION FROM BY TEACHER OR COMPUTER LAB STAFF.

Even with the above provisions, we cannot guarantee that a student will not gain access to objectionable material on the Internet. It is our expectation that students will use network resources and the Internet in a responsible manner. Students who will fully misuse available technology or network access will face disciplinary actions that may include loss of computer privileges.

Student's Name:_____ Date of Birth:_____

Teacher:_____ Grade:_____ Student ID:_____

_____ _____

Parent/Guardian Signature Date

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Appendix X-A

PERMISSION AND RELEASE TO PUBLISH ON THE INTERNET OR RADIO BROADCAST

All works including photographs that are published on the school website will be only in a group setting. If a student's sole photograph is published, this document will be referenced, and the school will adhere to the parent or guardian's request as indicated below:

As a parent or guardian of _____Grade:_____, I understand the benefits and risks of publishing on the Internet. In consideration of the benefits of allowing my child's his/her work, first/last name and/or picture on the school's web and Bobcat news (FB) page, I elect the following:

I give permission to publish my child's.

- ☐ *FIRST NAME ONLY* on the school website and Bobcat News.
- ☐ *FIRST and LAST NAME on the school website and Bobcat News.*
- ☐ *FIRST NAME ONLY and PHOTOGRAPH on the school's website and Bobcat News.*
- ☐ *FIRST and LAST NAME and PHOTOGRAPH on the school website and Bobcat News.*
- ☐ *FIRST and LAST NAME on Radio Broadcast (KUYI) for SMDS only.*

Further, I accept full responsibility for the publication as set forth in the publication and agree to release and hold the school harmless from all damages or injury to me or to the student arising from said publication.

PARENT/GUARDIAN
Printed Name:_____

PARENT/GUARDIAN
Signature:_____

DATE:_____

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Second Mesa Day School

SY 23-24

We, **Second Mesa Day School** community, establish this compact to foster the success of our students. We believe this is accomplished through the planned partnership of parents, families, students, teachers, and administrators. Goals that ensure academic achievement of the state standards; help every student develop a sense of responsibility and respect of self and others; and, provide guidelines for meaningful two-way communication between home and school are guaranteed through the following responsibilities in this agreement.

Teachers will provide high-quality curriculum and instruction in a supportive and effective learning environment that enables our students to meet Arizona's academic standards. In addition, I will:

Reading/Literacy

- Keep parents informed of the reading and math skills their children are learning, and how they can reinforce these skills at home.
- Guide students in selecting reading materials that match their interests and independent reading levels.

Study Habits/Self-Directed Learning

- Teach students how to study and encourage active listening skills.
- Provide homework assignments relevant to daily instruction in accordance with the school homework guidelines.

Respect/Responsibility

- Model and display responsible decision making and citizenship in all aspects of daily life.
- Maintain appropriate student behavior in the classroom so that all students can learn and be safe.

Community

- Communicate frequently with parents about their children's progress through quarterly report cards, and by notes, phone calls, and e-mails.

- Respond promptly to families' concerns, messages, and requests for information.
- Hold parent-teacher conferences, during which this compact will be discussed as it relates to the individual child's achievement.
- Encourage families to participate in school community programs and events.

Teacher Signature: _____

Students benefit when adults in their school community are bonded by strong relationships. They recognize that they, too, are partners with their parents and teachers in their success. I will:

Reading/Literacy

- Read regularly for pleasure as well as to learn.
- Ask my family to read with me or read to me 15 minutes each day 5 days a week.

Study Habits/Self-Directed Learning

- Listen to my family, teachers, and others who help me learn, and ask questions when I need help.
- Complete my homework on time and in a thorough and legible way.

Respect/Responsibility

- Come to school on time and ready to learn.
- Always try my best.
- Respect myself and the rights of others.

Community

- Deliver messages from school to home and home to school to help inform my parents and teachers of events and activities that help support my learning experience.
- Encourage my family to participate in events and programs sponsored by my school. (e.g. Open House, Family Nights, Parent/Teacher/Student Conferences)

Student Signature: _____

Parents/Families understand that involvement in their child's education is the number one determining factor in a child's academic success. To make education a top priority in our home, I will:

Reading/Literacy

- Read to or with my child 15 minutes per day 5 days a week.
- Help to reinforce our child's reading, writing, and math skills with direction of the teacher.
- Know our child's progress in reading, writing, and math in ways that show our high expectations.

Study Habits/Self-Directed Learning

- Make sure our child has a routine for homework that works for our family and follows our school's homework guidelines. If our child doesn't have homework on any given day, we will encourage independent reading time, (or read together if in K or 1st grade), review reading, writing, or math skills, or prepare for projects, quizzes, or tests.
- Review our child's homework and sign student planner each night.
- Discuss our child's effort and potential in ways that show high expectations.

Respect/Responsibility

- Make sure our child attends school regularly, is on time, and is prepared to learn.
- Stress the importance of school and classroom behavior expectations in family conversations.
- Encourage my child to demonstrate respect for school personnel, classmates, and school property.

Community

- Communicate promptly with my child's teacher whenever a concern or question arises.
- Respond promptly to my child's teacher or the school regarding requests or information.
- Attend/participate in open house, parent/teacher/student conferences, Family nights, or other school events.

Parent/Guardian Signature: _____

Our school helps to strengthen the family-school partnership to enhance student learning through our PAC Organization, Family Nights, parent meetings, classroom visits by parents/community, and communication about students' progress toward learning standards and BIE assessments. Family activities are posted on the SMDS website, Class Dojo, school marquee, SMDS Facebook page, and distributed through student delivery.

If you are interested in volunteering for our school, please complete the survey that will be available on the SMDS website at: https://www.secondmesadayschool.com. There will be orientation and training for all interested family and community members.

Please read and sign this Compact then return it the school. A copy of this compact will be on the school website mentioned above. We will refer to this compact at parent-teacher conferences and meetings that confirm our family-school partnership to enhance our students' learning.

Principal supports and encourages the efforts of all family-school partnerships at Second Mesa Day School.

Principal Signature Kimberly K. Thomas

SECOND MESA DAY SCHOOL

"Home of the Mighty Bobcats"

YEARLY ATHLETIC
&
P.E. PACKET

HOPI ELEMENTARY ATHLETIC LEAGUE

- Cross Country (3rd – 6th)
- Basketball (3rd – 6th)
- Cheerleading (3rd – 6th)

SY 2023/2024

SECOND MESA DAY SCHOOL
PO BOX 98
SECOND MESA, AZ
(928) 737-2571

Second Mesa Day School
Mighty Bobcats
P.O. Box 98 Second Mesa, Az 86043.
Phone: 928-737-2571. Fax: 928-737-2565

Annual Health Questionnaire for Sports Participation Grades K – 6th

Students Name: _____ **Grade Level:** _____

D.O.B _____ **Gender: Male – Female**

Parents/Guardians Name: _____ **Phone Number:** _____

Family Physician: _____ **Phone Number:** _____

Allergies: _____

Please answer the following questions by circling the answer:

1.	During the past 12 months, was your child hospitalized?	YES	NO
2.	During the past 12 months, has your child had surgery?	YES	NO
3.	During the past 12 months, has your child had any injuries that required medical attention?	YES	NO
4.	Does your child take medication daily?	YES	NO
5.	Do you feel that there should be limits on your child's sports participation, because of symptoms of illness or injury?	YES	NO
6.	Do you feel there should be limits on your child's sports participation, because of family history?	YES	NO
7.	Has your child ever fainted while exercising?	YES	NO

If you answered "YES" to any of the above questions, your child will require a pre-participation physical exam by a medical physician to be cleared for sports participation.

We, the undersigned, have answered the above questions to the best of our ability. The information given is accurate, and we understand the school personnel will rely on the information provided.

_____ _____

Parent/Guardian Signature **Date**

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Sports/Activities
CONSENT FOR EMERGENCY CARE FORM

STUDENT-ATHLETE NAME: _____ **Grade:**_____

As parent(s) or legal-guardian of the student-athlete stated above I/We hereby give consent for a medical provider to render such aid, treatment, or care in a medical facility (Hospital) to my child as required on a needed emergency basis.

In the event should my child be injured or stricken ill while participating in a Second Mesa Day School sponsored sports activities, I (We) hereby give permission for school coaches to administer first aid to my son/daughter. By signing below, it is hereby understood that this consent and authorization granted shall extend throughout the current school year.

SIGNATURE: _____ **DATE:** ____/____/____
(Parent or Legal Guardian)

Home Phone Number: _____ **Cell Phone #:** _____

Bobcat Athletics Mission Statement

"Second Mesa Day School Bobcat (SMDS) Athletics provides positive encouragement and commitment of all extra-curricular opportunities to all student-athletes for excellence and acquiring skills needed to develop positive self-esteem and positive self-confidence as a student-athlete, while supporting the educational mission in creating a positive and safe learning".

Requirements for practice:

Students are required to bring clothing/items for practice such as (t-shirt, short cuts, athletic shoes and water bottle). Storage lockers will be provided for each student for storing apparel/items and to minimize absence from practice. **(However student must provide their own combination type lock. (NO KEY LOCK TYPE as keys do get misplaced)**

School Eligibility Requirements:

Weekly progress reports received from teachers for each student will determine student-athlete eligibility. If your student-athlete is **ELIGIBLE** for the week, they will be allowed to stay after school for practice. If students are **INELIGIBLE**, they will not be participating in practice or school sponsored games or meets until their status has changed to be eligible.

Zero Tolerance for Misbehavior:

Bullying, Misconduct and/or Suspension referrals to the principal's office will not be tolerated. If evidence is provided to the coaching staff, there will be consequences and possible removal from the team, as well as determining further participation in all school sponsored sports for the **2023-2024** school year. During sports practice, and games your son/daughter is representing SMDS Bobcats, as well as your families, therefore all inappropriate behavior or foul language will not be tolerated and may result in non-participation. The athletic department is required to enforce a 3-strike system for the entire **2023-2024 School Year,** that will reflect on their behavior school wide and will determine their participation throughout all school sports for the academic year.

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Expectations of a Student-Athlete:

At SMDS, the coaching staff encourages student-athletes to become positive, self-motivated, and be that lead example of being role models. When we travel off school campus to another school environment, we expect our student-athletes to demonstrate good behavior, attitude and portray their bobcat spirit through positive sportsmanship. This also applies, not only for sports, but being a SMDS Bobcat to demonstrate **PAWSOME** attributes in the classroom.

SMDS Supports and Encourages each student-athlete to strive for excellence in the classroom to maintain their academic and sports eligibility. Student athletes will be mandated to participate in a **60 MINUTE STUDY HALL** to help with their school homework for the day. If a student-athlete has no homework, he/she is **REQUIRED TO BRING AN ACCEPTABLE BOOK TO READ.**

GOOD SPORTMANSHIP is what we encourage here at SMDS. Coaches and Staff appreciate all parents/guardians and community for support and encourage your student-athlete to demonstrate this important quality that reflects not only the team, but families as well. This is a quote we share among the student-athletes,

"Winning is not everything, to succeed you first have to lose, before you learn to win"

Conduct of Parents/Guardians and Community:

SMDS/Athletics encourages parents/guardians and community to support their student-athlete while participating and demonstrating positive behavior and good sportsmanship. Behavior, attitude and respect reflect who we are as role models for our children. Please adhere to the protocol set forth for addressing concerns from parents/guardians and community as follows: (1st Approach - Head Coach, 2nd Approach - Head Coach & Principal). **Parents/Guardians and Community must understand and be respectful to all Second Mesa Day School Athletics participants by refraining from using social media (Facebook, Instagram, Snap Chat, Tik Tok, etc.) as a negative outlet.** Any concerns or situations will be brought to the attention of Coaches and Principal to ensure proper procedures are followed and resolved in a respectable manner. We appreciate you taking the time to read and initial where needed. We look forward to establishing a great supportive network for all Bobcat student-athletes.

Parent Signature: _____ **Date:** _____/_____/_____
(Parent or Legal Guardian)

Student Signature: _____ **Date:** _____/_____/_____
(Student-Athlete)

If you have any questions, contact SMDS Office @ 928-737-2571.

Received on: _____/_____/_____ By: _____
(Physical Education Teacher)

AIA

ARIZONA INTERSCHOLASTIC ASSOC.
7007 N. 18TH ST., PHOENIX, AZ 85020
PHONE: (602) 385-3810

2023-24 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

NextCare URGENT CARE
EXCLUSIVE URGENT CARE PARTNER OF THE AIA

(The parent or guardian should fill out this form with assistance from the student-athlete) Exam Date: _____

Name: _____
Home Address: _____
Phone: _____
Date of Birth: _____
Age: _____
Gender: _____
Grade: _____
School: _____
Sport(s): _____
Personal Physician: _____
Hospital Preference: _____

In case of emergency contact:
Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

	Y	N
1) Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2) Do you have an ongoing medical conditional (like diabetes or asthma)?	☐	☐
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____	☐	☐
4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify): _____	☐	☐
5) Does your heart race or skip beats during exercise?	☐	☐
6) Has a doctor ever told you that you have (check all that apply):	☐	☐
☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ A Heart Infection		
7) Have you ever spent the night in a hospital?	☐	☐
8) Have you ever had surgery?	☐	☐
9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11)	☐	☐
10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11):	☐	☐
11) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below):	☐	☐

☐ Head ☐ Neck ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm
☐ Hand/Fingers ☐ Chest ☐ Upper Back ☐ Lower Back ☐ Hip ☐ Thigh
☐ Knee ☐ Calf/Shin ☐ Ankle ☐ Foot/Toes

	Y	N
12) Have you ever had a stress fracture?	☐	☐
13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	☐	☐
14) Do you regularly use a brace or assistive device?	☐	☐
15) Has a doctor told you that you have asthma or allergies?	☐	☐
16) Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
17) Is there anyone in your family who has asthma?	☐	☐
18) Have you ever used an inhaler or taken asthma medication?	☐	☐
19) Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle or any other organ?	☐	☐
20) Have you had infectious mononucleosis (mono) within the last month?	☐	☐
21) Do you have any rashes, pressure sores or other skin problems?	☐	☐
22) Have you had a herpes skin infection?	☐	☐
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	☐	☐
24) Have you ever had a seizure?	☐	☐
25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	☐	☐
26) While exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
28) Have you ever been tested for sickle cell trait?	☐	☐
29) Have you had any problems with your eyes or vision?	☐	☐
30) Do you wear glasses or contact lenses?	☐	☐
31) Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
32) Are you happy with your weight?	☐	☐
33) Are you trying to gain or lose weight?	☐	☐
34) Has anyone recommended you change your weight or eating habits?	☐	☐
35) Do you limit or carefully control what you eat?	☐	☐
36) Do you have any concerns that you would like to discuss with a doctor?	☐	☐

Females Only

	Y	N
37) Have you ever had a menstrual period?	☐	☐
38) How old were you when you had your first menstrual period?	_____	
39) How many periods have you had in the last year?	_____	

Explain "Yes" Answers Here

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: _____ Date of Birth: _____

Patient History Questions: Please Tell Me About Your Child...

		Y	N
1)	Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	☐	☐
2)	Has your child ever had extreme shortness of breath during exercise?	☐	☐
3)	Has your child had extreme fatigue associated with exercise (different from other children)?	☐	☐
4)	Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	☐	☐
5)	Has a doctor ever ordered a test for your child's heart?	☐	☐
6)	Has your child ever been diagnosed with an unexplained seizure disorder?	☐	☐
7)	Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	☐	☐

Explain "Yes" Answers Here

COVID-19...

		Y	N
1)	Has your child been diagnosed with COVID-19?	☐	☐
1a)	If yes, is your child still having symptoms from their COVID-19 infection?	☐	☐
2)	Was your child hospitalized as a result for complications of COVID-19?	☐	☐
3)	Has your child been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)?	☐	☐
4)	Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist) to be cleared to return to sports?	☐	☐
5)	Has your child returned back to full participation in sports?	☐	☐
6)	Has your child had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?	☐	☐
6a)	Was your child tested for COVID-19?	☐	☐
7)	Did your child receive the COVID-19 vaccine?	☐	☐

7a) What was the manufacturer of the vaccine? _____

7b) Date of vaccination(s) _____

Explain "Yes" Answers Here

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last two weeks, how often have you been bothered by any of the following problems? (circle responses)

	Not At All	Several Days	Over Half The Days	Nearly Every Day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

If you score a sum of 3 or greater on either questions 1 and 2, or 3 and 4, you may have anxiety or depression that is affecting you more than normal. In this case, it is recommended that you talk to a trusted health care provider such as your primary care physician, your athletic trainer at school, or a counselor at school. If there is not someone you feel comfortable talking to or you are interested in learning more to help yourself or a friend, please use the resources provided below.

For more information regarding student-athlete mental health:
Quiet Suffering - A Resource for Student-Athlete Mental Health
spark.adobe.com/page/lLtwyoLpTAp0V/

Teen Lifeline Call and Text Crisis Line
(602) 248-8336 (TEEN)
Outside Maricopa county call: 1-800-248-8336 (TEEN)
Hours are: Call 24/7/365 | Text weekdays 12-9 p.m. & weekends 3-9 p.m. | Peer counseling 3-9 p.m. daily
Crisis text line: Text HOME to 741741 to connect with a crisis counselor

National Suicide Prevention Lifeline
1-800-273-8255 or suicidepreventionlifeline.org

The Trevor Lifeline
866-488-7386 (for gender diverse youth)

Family History Questions: Please Tell Me About Any Of The Following In Your Family...

		Y	N
1)	Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowning or near drowning)	☐	☐
2)	Are there any family members who died suddenly of "heart problems" before age 50?	☐	☐
3)	Are there any family members who have unexplained fainting or seizures?	☐	☐
4)	Are there any relatives with certain conditions, such as:		

	Y	N		Y	N
Enlarged Heart	☐	☐	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	☐	☐
Hypertrophic Cardiomyopathy (HCM)	☐	☐	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	☐	☐
Dilated Cardiomyopathy (DCM)	☐	☐	Marfan Syndrome (Aortic Rupture)	☐	☐
Heart Rhythm Problems	☐	☐	Heart Attack, Age 50 or Younger	☐	☐
Long QT Syndrome (LQTS)	☐	☐	Pacemaker or Implanted Defibrillator	☐	☐
Short QT Syndrome	☐	☐	Deaf at Birth	☐	☐
Brugada Syndrome	☐	☐			

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of Student-Athlete _____ Signature of Parent/Guardian _____ Date _____

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP _____ Date _____

AIA
ARIZONA INTERSCHOLASTIC ASSOC.
7007 N. 18TH ST., PHOENIX, AZ 85020
PHONE: (602) 385-3810

2023-24 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name: _____ Date of Birth: _____
Age: _____ Sex: _____
Height: _____ Weight: _____
% Body Fat (optional): _____ Pulse: _____
BP: ____ / ____ (____ / ____, ____ / ____)
Vision: R20/____ L20/____ Corrected: Y ☐ N ☐
Pupils: Equal ☐ Unequal ☐

	Normal	Abnormal Findings	Initials *
Medical			
Appearance	☐		
Eyes/Ears/Throat/Nose	☐		
Hearing	☐		
Lymph Nodes	☐		
Heart	☐		
Murmurs	☐		
Pulses	☐		
Lungs	☐		
Abdomen	☐		
Genitourinary &	☐		
Skin	☐		
Musculoskeletal			
Neck	☐		
Back	☐		
Shoulder/Arm	☐		
Elbow/Forearm	☐		
Wrist/Hands/Fingers	☐		
Hip/Thigh	☐		
Knee	☐		
Leg/Ankle	☐		
Foot/Toes	☐		

* - Multi-examiner set-up only | & - Having a third party present is recommended for the genitourinary examination

NOTES:

Cleared Without Restriction ☐
Cleared With Following Restriction: _____
Not Cleared For: ☐ All Sports ☐ Certain Sports: _____ Reason: _____
Medically eligible for all sports without restriction with recommentations for further evaluation or treatment of:

_____

Recommendations: _____

Name of Physician (Print/Type): _____ Exam Date: _____
Address: _____ Phone: _____
Signature of Physician: _____ , MD/DO/ND/NMD/NP/PA-C/CCSP

 NextCare is the preferred partner of the AIA. It is not required you visit NextCare locations for your healthcare needs.

AIA ARIZONA INTERSCHOLASTIC ASSOCIATION

OUR STUDENTS, OUR TEAMS . . . OUR FUTURE.

Arizona Interscholastic Association, Inc.
Mild Traumatic Brain Injury (MTBI) / Concussion
Annual Statement and Acknowledgement Form

I, _____ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the school staff (e.g., coaches, team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the CDC Concussion fact sheet (http://www.cdc.gov/concussion/HeadsUp/youth.html) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spiritline and wrestling.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:
Print Name: _____ Signature: _____ Date: _____

Parent or legal guardian must print and sign name below and indicate date signed:
Print Name: _____ Signature: _____ Date: _____

2023-24 CONSENT TO TREAT FORM

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return to play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, as a member of the Arizona Interscholastic Association (AIA), _____ (name of school or district) requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district/AIA, to the extent the QMP deems necessary to prevent harm to the student-athlete. It is understood that a QMP may be an athletic trainer, physician, physician assistant or nurse practitioner licensed by the state of Arizona (or the state in which the student-athlete is located at the time the injury/illness occurs), and who is acting in accordance with the scope of practice under their designated state license and any other requirement imposed by Arizona law. In emergency situations, the QMP may also be a certified paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designate

PLEASE PRINT LEGIBLY OR TYPE

"I, _____, the undersigned, am the parent/legal guardian of, _____,

a minor and student-athlete at _____
(name of school or district) who intends to participate in interscholastic sports and/or activities.

I understand that the school/district/AIA employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic athletes before, during or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return to play in accordance with the defined scope of practice under the designated state license, except as otherwise limited by Arizona law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return to play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the physician or provider of his/her choice. I understand, however, that all decisions regarding same day return to activity following injury/illness shall be made by the QMP employed/designated by the school/district/AIA.

Date: _____ Signature: _____

Second Mesa Day School
P.O. Box 98 Second Mesa, Arizona 86043
Phone: 928-737-2571
Fax: 928-737-2565

Student Residency Verification Document

This document is intended to address the McKinney-Vento Act. This document will be used by school personnel and partnering agencies to ensure all providers have the necessary information to help support your child (student) and his/her family.

Name of Student_____ Grade _____

☐ Male ☐ Female Birth Date _____/_____/_____ Age:_____

Name of Parent(s)/Legal Guardian(s)_____

Address_____ Zip_____

Phone Contacts:_____

1. Presently, where is the student living? *Check one box*

Section A	Section B
☐ In a shelter; ☐ With more than one family in a house or apartment; ☐ In a motel, car or campsite; ☐ With friends or family members (other than parent/guardian) **Continue:** *if you checked a box in **Section A,** Complete #2 and the remainder of this form*	☐ Choices in Section A do not apply **STOP:** *If you checked this section, you do **not** need to complete the remainder of this form. Submit to school personnel.*

2. The student lives with:

☐ 1-parent
☐ 2-parents
☐ 1 parent & another adult
☐ a relative, friend(s) or other adult(s)
☐ alone with no adults
☐ an adult that is not the parent or legal guardian

Signature of Parent/Legal Guardian_____ Date _____

School Use Only-School Administrator's determination of Section A circumstances:

If the parent has checked Section B above, completion of this form is not required. For any choices in Section A, this form must be completed and provided to School Registrar immediately upon completion. Form will be kept separately from Student Permanent Record for audit purposes during the year. SMDS Parent Liaison may be notified about family's situation.