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"

May 29, 2024

Dear Parents/Guardians:

THANK YOU and WELCOME BACK to Second Mesa Day School**, "HOME OF THE MIGHTY BOBCATS!** We look forward to another great successful school year 2024-2025.

This packet will serve as your **formal confirmation that your child has been invited to return to Second Mesa Day School for the 2024-2025 school year.**

The check-off list will be used as a guide for completing your child's enrollment. All forms must be completed and signed with all required documents on file to be considered complete.

Our first day of school is scheduled to start on Monday, August 12, 2024.

SMDS continue to encourage all parents/guardians and families to be engaged with their children's academic, athletic, and social needs to meet their desires. We look forward to working with you and your children for another great and wonderful school year! **"ITAH TSATSAYOM MOPEKYA"**

Sincerely,

Mrs. Kimberly Thomas, Principal/CSA
Second Mesa Day School

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

RETURNING STUDENT Registration Checklist

SCHOOL YEAR 2024-2025

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*

______*Parental Consent Form*

______*Student Check-Out/Transportation Form*

______*Medical Attention Form*

______*Student Health History-Part I & II*

______*Library Permission Form*

______*HHCC Dental Screening Form*

______*HHCC Influenza Vaccination Form*

______*Home Language Survey Form*

_______*Technology – Student Usage Agreement*

_______*Internet Acceptable Use Policy*

_______*McKinney-Vento Form*

_______*Physical Examination Form*

** ***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 2024 - 2025

** 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

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SY 2024-2025
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 ☐ 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

Signature of Parent/Legal Guardian: ______________________________________ Date ____________________

SY 2024 - 2025
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.")
** Only 5 Individuals will be allowed (If you wish to change the list, please provide letter and/or make Changes with Registrar's Office).

	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 2024 - 2025
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 2024-2025 **MUST** have a physical done prior to the 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 students' 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. Students 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 to 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, 2025

SECOND MESA DAY SCHOOL
P.O. Box 98
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SY 2024 - 2025
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: ____________

Administering Medicine To Students
Part II

Student Name: ____GRADE: ______________

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 2024-2025.

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 ______________________________ District Student ID ____________________

Date of Birth ______________________________ SSID ____________________

Parent/Guardian Signature ______________________________ Date ____________________

District or Charter ____

School ____

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

In AzEDS, please indicate the student's home or primary language. (Revised 01-2019)

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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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Internet Acceptable Use Policy

Second Mesa Day School (SMDS) offers staff and students access to a computer network for educational and instructional purposes. In addition, SMDS offers staff and students access to the Internet. Internet access is intended to promote, enhance, and support educational goals and objectives. To gain access to the SMDS network and the Internet, all students under the age of 18 must obtain parental permission. All staff, students, visitors, vendors/contractors must sign the Internet Acceptable Use Policy, if they are going to access the school internet onsite. A copy of the IAUP signed by a staff member will be kept at the personnel office. Students 18 and over may sign their own forms.

CIPA COMPLIANCE
Second Mesa School has and will continue to comply with the requirements of the Children's Internet Protection Act, (CIPA) as codified at 47 U.S.C. § 254(h) and (l). SMDS is committed to assuring the safe conduct of all students while online and has a comprehensive policy about the proper use of our technological resources. At the beginning of each school year, students and staff are made aware of SMDS Internet Acceptable Use Policy. In addition, each student's parent and/or guardian must sign and Internet use agreement before they are allowed access to the Internet and the SMDS network. It is the SMDS's intent to preserve network bandwidth and improve network response times by limiting Internet access to educational-related sites. The filtering software used to block and filter access to the Internet from pornographic and obscene sites is SMDS's DNS Filter, ensuring compliance with distract policies and maintaining a positive online environment.

INTERNET SERVICES
Access to the Internet expands classroom and library media resources. These enable staff and students to explore thousands of libraries, databases, and other information resources. These resources can be used for individual and group projects, collaborations, curriculum materials and idea sharing.

INTERNET RESPONSIBILITIES
With access to the Internet comes responsibility. SMDS has installed an Internet filtering application and a Firewall to help protect students from inappropriate material while they are accessing Internet resources at school. Filtering is effective but not perfect. Staff must be vigilant in monitoring student use of technology systems and prepared to enforce the guidelines found within this policy (IAUP). Parents and guardians of minors are responsible for setting and conveying the standards that their children should follow when using any media and informational sources. Students are responsible for appropriate behavior when using electronic devices and resources. When signing the Internet Acceptable Use Policy, the students and parent agree to abide by the policies set forth by SMDS.

SMDS is held harmless and released from liability for ideas and concepts that students gain by their use of the Internet.

SMDS NETWORK SERVICES

Each staff member and student are provided with a network account, which allows access to the SMDS network and services. This access to network services is provided for those who agree to act in a considerate and responsible manner. Access is a privilege, not a right. Network accounts provide for a limited amount of personal storage space (SMDS Share Folder) on the SMDS network for files related to the pursuit of education, which should be maintained by periodically clearing out older files.

It is important for staff and students to keep passwords secure and private. However, all users should be aware that teachers and administrators have the right to review files to maintain system integrity ad to be sure that the system is being used according to the SMDS Board policy.

SMDS employs an extensive back-up of data each week. Copies are stored both on-site and off-site for additional security. Employee files can be saved if saved to their Network Share Folder.

SMDS NETWORK ACCESS RESPONSIBILITIES

Individual user of SMDS technology is responsible for their behavior and communication over those networks. Users will only use their personal Network ID to login to the SMDS network (some elementary students will use a generic classroom ID). When signing the IAUP users agree to comply with SMDS rules and policies.

SMDS makes no warranties of any kind either expressed or implied, for the provided access. The staff, school and SMDS are not responsible for any damages incurred, including, but not limited to, the lost of data stored on SMDS resources, to personal property used to access SMDS resources, or for the accuracy, nature or quality of information stored on SMDS resources.

RESTRICTIONS

The following activities are not permitted on SMDS electronic resources:

- Accessing, uploading, downloading, transmitting, displaying, or distributing obscene or sexually explicit material.
- Accessing, uploading, downloading, transmitting, displaying, or distributing unauthorized files or applications of any kind (including but not limited to games, IM clients, VPN’s, and Internet Proxies).
- Transmitting obscene, abusive, or sexually explicit language.
- Damaging or vandalizing computers, computer systems, computer networks or computer files.
- Debilitating, disabling, or altering computers, systems, or networks.
- Creating, downloading, or distributing computer viruses or parts of computer viruses.
- Violating copyright or otherwise using another person’s intellectual property without his or her prior approval and or proper citation.
- Using another person’s account, password, folder, work, or files.
- Intentionally wasting computer network or printer resources.
- Using the SMDS network or equipment for personal, commercial, or political purposes.
- Violating local, state, or federal statutes.

CONSEQUENCES FOR IMPROPER USE

Inappropriate use of SMDS technology will result in the restriction or cancellation og the user’s account. Violation of the IAUP may lead to disciplinary and/or legal action, including but not limited to suspension, expulsion and termination, or criminal prosecuting by government authorities.

SECOND MESA DAY SCHOOL
Internet Acceptable Use Policy
Agreement

USER AGREEMENT

As a user of Second Mesa Day School's computer network, I agree to comply with the Internet Acceptable Use (IAUP). I will use the SMDS network and the Internet in a constructive and appropriate manner. Should I commit any violation, my access privileges may be revoked, and disciplinary action will be taken.

☐ STAFF MEMBER ☐ STUDENT ☐ OTHER USER

USER (Please Print)____

USER SIGNATURE:____

STAFF POSITION/HOMEROOM TEACHER:______________________________

SMDS STUDENTS AND PARENTS WILL COMPLETE THIS PAGE WITH THEIR SIGNATURE FORM FOR REGISTRATION.

As parent or legal guardian of the student above, I have read and understood the SMDS Internet Acceptable Use Policy.

______ I grant permission for my child to access the SMDS network and Internet resources. I understand that he/she is expected to use good judgement and follow rules and guidelines when using the SMDS network and Internet resources. I agree to comply with the SMDS Internet Acceptable Use Policy (IAUP)

______ I DO NOT grant permission for my child to access Internet resources while at school. I understand that my child will still have access to the SMDS network and is expected to follow the rules and guidelines for the appropriate use of the network as stated in the Internet Acceptable Use Policy (IAUP).

Parent Name (please print)____

Parent Signature:____

Date:______________________________

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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* in Section A or Section B

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 this box section, you do* ***not*** *need to complete the remainder of this form,* ***please sign/date and submit to school personnel****.*

2. The student lives with:

☐ 1-parent ☐ a relative, friend(s) or other adult(s)

☐ 2-parents ☐ alone with no adults

☐ 1 parent & another adult ☐ 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.

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

2024-25 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

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: ______________
Sex Assigned at Birth: ______________
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) List past and current medical conditions: ______________		
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 stinging 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 had surgery? (Please list): ______________	☐	☐
8) 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 10)	☐	☐
9) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 10):	☐	☐
10) 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

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NextCare URGENT CARE
EXCLUSIVE URGENT CARE PARTNER OF THE AIA

	Y	N
11) Have you ever had a stress fracture?	☐	☐
12) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	☐	☐
13) Do you regularly use a brace or assistive device?	☐	☐
14) Has a doctor told you that you have asthma or allergies?	☐	☐
15) Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
16) Have you ever used an inhaler or taken asthma medication?	☐	☐
17) Do you have groin or testicular pain, or a painful bulge or hernia in the groin area?	☐	☐
18) Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle or any other organ?	☐	☐
19) Have you had infectious mononucleosis (mono) within the last month?	☐	☐
20) Do you have any rashes, pressure sores or other skin problems?	☐	☐
21) Have you had a herpes skin infection?	☐	☐
22) 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")?	☐	☐
23) Have you ever had a seizure?	☐	☐
24) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	☐	☐
25) While exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
26) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
27) Have you ever been tested for sickle cell trait?	☐	☐
28) Are you happy with your weight?	☐	☐
29) Are you trying to gain or lose weight?	☐	☐
30) Has anyone recommended you change your weight or eating habits?	☐	☐
31) Do you limit or carefully control what you eat?	☐	☐
32) 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

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

AIA

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2024-25 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

NextCare URGENT CARE

EXCLUSIVE URGENT CARE PARTNER OF THE AIA

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

Student Name: ______________________________ Date of Birth: ________________

Patient History Questions: Please Share 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)	Was your child hospitalized as a result for complications of COVID-19?	☐	☐
2)	Has your child had any long-term complications from COVID-19?	☐	☐
3)	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?	☐	☐

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
988 or suicidepreventionlifeline.org

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

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Family History Questions: Please Share About Any Of The Following In Your Family

		Y	N
1)	Are there any family members who had sudden/unexpected/unexplained death before age 35? (including SIDS, car accidents drowning or near drowning)	☐	☐
2)	Are there any family members who died suddenly of "heart problems" before age 35?	☐	☐
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 35 or Younger	☐	☐
Long QT Syndrome (LQTS)	☐	☐	Pacemaker or Implanted Defibrillator	☐	☐
Short QT Syndrome	☐	☐	Deaf at Birth	☐	☐
Brugada Syndrome	☐	☐			

Explain "Yes" Answers Here

Additional History

		Y	N
1)	Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff or dip?	☐	☐
2)	Do you drink alcohol or use illicit drugs?	☐	☐
3)	Have you ever taken anabolic steroids or used any other performance-enhancing supplements?	☐	☐
4)	Have you ever taken any supplements to help you gain or lose weight, or improve your performance?	☐	☐
5)	Do you always wear a seatbelt while in a vehicle?	☐	☐

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 ____________

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2024-25 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

EXCLUSIVE URGENT CARE PARTNER OF THE AIA

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

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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: __________

FORM 15.7-C 06/2015