ATTORNEY-IN-FACT AFFIDAVIT[1]

I certify that I am the parent or legal custodian of:

Full name of minor child	Date of birth
Full name of minor child	Date of birth
Full name of minor child	Date of birth
Full name of minor child	Date of birth

I designate the following individual as the attorney-in-fact for each minor child named above:

Full name of attorney-in-fact

Street address, city, state and zip code of attorney-in-fact

Home phone, attorney-in-fact	Work phone, attorney-in-fact

I provide the attorney-in-fact the following authority:

_____I delegate to the attorney-in-fact all of my power and authority regarding the care, custody and property of each minor child named above, including but not limited to the right to enroll the child in school, inspect and obtain copies of education records and other records concerning the child, the right to attend school activities and other functions concerning the child, and the right to give or withhold any consent or waiver with respect to school activities, medical and dental treatment, and any other activity, function or treatment that may concern the child. This delegation shall not include the power or authority to consent to marriage or adoption of the child, the performance or inducement of an abortion on or for the child, or the termination of parental rights to the child.

OR

_____I delegate to the attorney-in-fact the following specific powers and responsibilities:

[1] Student residency cannot be established through an attorney-in-fact relationship without this fully completed document.

_____

_____

This delegation shall not include the power or authority to consent to marriage or adoption of the child, the performance or inducement of an abortion on or for the child, or the termination of parental rights to the child.

Effective Dates

This power of attorney is effective for a period not to exceed one year (12 calendar months), beginning on _____, 20____ and ending _____, 20___. I reserve the right to revoke this authority at any time. I understand that in order to extend this power of attorney beyond one year I must execute and deliver to the district a new power of attorney.

Signatures

I hereby make these designations as specified above.

_____

Parent signature Date

I hereby accept my designation as attorney-in-fact for the minor child(ren) specified in this power of attorney.

_____

Attorney-in-fact signature Date

Acknowledgment

Before me, the undersigned, a Notary Public, in and for said County and State on this _____ day of _____, 20_____, personally appeared _____ (name of parent/legal custodian) and _____ (name of attorney-in-fact) to me known to be the identical persons who executed this instrument and acknowledged to me that each executed the same as his or her free and voluntary act and deed for the uses and purposes set forth in the instrument.

Witness my hand and official seal the day and year above written.

_____

Signature of notarial officer

_____

My commission expires(Seal)

AFFIDAVIT OF PERSON WHO HAS
ASSUMED PERMANENT CARE AND CUSTODY OF STUDENT

STATE OF OKLAHOMA)
) SS:
County of Pawnee)

The undersigned, being of lawful age and after being duly sworn upon oath, state as follows:

I presently reside at _____
which is within the geographical boundaries of the Cleveland School District.

I can be contacted by phone at ____-____-_____.

I have assumed the permanent care and custody of:

_____ DOB_____ Grade _____

_____ DOB_____ Grade _____

_____ DOB_____ Grade _____

The child(ren) listed above are minor(s), and I desire to enroll said minor(s) in the Cleveland School District. I understand that "permanent care and custody" means that I have assumed responsibility for the care and custody of said minor(s) on a continuous and ongoing basis, and I do not intend to relinquish such care and custody until said minor(s) reaches the age of majority.

The reason(s) that I have assumed the permanent care and custody of the above-named minor(s) are stated **in detail** as follows:

I contribute the major degree of support to the above-named minor(s).

I further understand that the statements made in this Affidavit are made under oath and that knowingly filing a false Affidavit of Residency is a misdemeanor, punishable by imprisonment in the County jail for not more than one (1) year OR a fine of not more than $500.00, OR both.

_____ _____
Print Name Signature

SUBSCRIBED AND SWORN TO before me, a Notary Public, this ____ day of _____, 20____.

My Commission Expires: _____ _____

Notary Public Signature
(Seal)

APPLICATION FOR TRANSFER UNDER THE DEPLOYED PARENTS SCHOOL ACT OF 2013

1. Full name of student as it appears on the student's birth certificate:

_____

2. Date of student's birth: _____

3. Current address of student: _____

4. Full name(s) of student's parent(s): _____

5. Name of parent on active duty (copy of Department of Defense ID card required):

_____

6. Full name of student's custodian(s) during parent's active duty:

_____

7. Address of custodian(s):

_____

8. Period of parent's active duty (copy of orders required):

_____

9. School district in which student currently resides: _____

10. School district which student attends, if different from above: _____

11. Current or last completed grade of student: _____

12. Grade in which the student desires to enroll: _____

13. Courses in which the student desires to enroll in each semester in the coming school year:

_____

_____

14. If the student has been identified as a child with a disability, this district will need to review all such records to implement the student's current or anticipated Individualized Education Program (IEP) and conduct the statutorily-required joint IEP conference with the resident school district. Is the student currently, or has the student been, a child with a disability who received an IEP?
Yes _____ No _____

If Yes: Briefly describe the nature of the disability; the approximate time period in which the student has been, or was, under an IEP; and the names of the school districts which implemented the student's IEP:

_____

_____

15. Do you agree to complete the Consent for Release of Confidential Information, allowing this district to review all educational records of the student from all previous schools attended by the student?

Yes _____ No _____

Cleveland Public Schools

Notice of Out-of-School Suspension and Right to Suspension Conference

Student _____ Date _____

Parent/Guardian _____ Grade _____ DOB _____

Address _____

_____ is being suspended out of school from the Cleveland Public Schools for _____. The out-of-school suspension will commence on _____, with the student allowed to return_____ .

The reason(s) for the out-of-school suspension is/are:_____ _____

I held a conference with the student today during which I explained the reasons for the out-of-school suspension and gave the student the opportunity to explain his/her side of the case.

Before recommending out-of-school suspension, I considered alternative in-school placements, including, but not limited to, placement in an alternative school setting, reassignment to another classroom, and placement in in-school detention. I determined that these and other available options were inappropriate because: _____ _____

I invite and encourage you as the student's parents to meet with me to discuss your child's behavior and any reasons you may have why the out-of-school suspension should not be imposed. I will be available to meet with you in my office on _____ at _____ ____.m. Please call _____ if you have any problems with the time or date of the conference.

The out-of-school suspension goes into effect on the date stated above unless (1) on meeting with you, I agree that the suspension should not go into effect, (2) you submit a request for appeal in accordance with the appeal rights listed on the back of this form, or (3) the following paragraph is applicable (if the following paragraph applies to your student's suspension, the principal will initial the paragraph below).

> _____ This out-of-school suspension is effective immediately because the student's conduct indicates that his/her continued attendance at school pending review or waiver of review of the out-of-school suspension would be dangerous to other students, staff, or school property or would substantially interfere with the educational process.

When the out-of-school suspension goes into effect, the student is prohibited from being on any school premises <u>at any time</u>, before, during, or after school. Notwithstanding the filing of an appeal, the student immediately forfeits the privilege of participating in all extracurricular activities of the school.

I acknowledge receipt of this notice at the conclusion of the conference with the principal.

Student Signature

Parent/Guardian Signature (if available)

This notice has been hand-delivered to the named student (with instructions to deliver it to his/her parent or guardian) and mailed to the parent/guardian on this date.

Administrator Signature

Date

☐ Enclosed is a copy of student rules with violation circled.
☐ Letter sent to parent/guardian by registered or certified mail.
☐ Enclosed is a copy of Parent Rights in Special Education (only for children with disabilities).

Distribution: ☐ Student ☐ Parent/Guardian ☐ Superintendent

Rights in Special Education

Student Rights

- Have relevant policies and school regulations explained so that he/she can understand them.
- Be notified of the policy, rule or regulation allegedly violated.
- Be allowed to explain his/her version of the alleged violation.
- Have a meeting with the principal before the suspension (if the conduct constitutes an immediate danger, the conference will be held as soon as possible after removal).
- Be notified of the length of any out of school suspension.

Parent / Guardian Rights

- Be notified by phone and in writing of the suspension, including the alleged violations and the other options which were considered and rejected prior to suspension.
- Have a conference with principal during regular school hours; conference includes explanation, in a way the parent/guardian can understand, of (1) the policy, rule or regulation the student allegedly violated, (2) student's alleged conduct, (3) options considered in lieu of suspension, and reason for rejecting those options.
- A final principal decision after the conference regarding whether the suspension will be terminated or modified.
- Advance notice prior to mid-day dismissal of elementary and middle school students.

All out of school suspensions may be appealed as follows:

Ten (10) Days or Less (short term)

- A student/parent/guardian has the right to appeal a suspension decision to a Suspension Review Committee (SRC) within 5 days of the initial notice of the suspension. The appeal must be made in writing.
- The SRC will meet as soon as possible to review the suspension. The principal will notify the student/parent/guardian of the date, time and place of the hearing at least 24 hours prior to the hearing.
- The student/parent/guardian have the right to be present at the hearing and present evidence and witnesses to support their position. Any party wishing to have legal counsel present must give the other party 24 hours advance notice or may not have counsel present.
- The SRC will determine the student's guilt or innocence and the reasonableness of the term of the suspension. The SRC will sustain, rescind, or modify the suspension. The decision of the SRC is final and nonappealable unless the SRC determines the suspension should be increased in excess of 10 days. In that event, the appeal procedures for long-term suspensions shall apply.

Greater Than Ten (10) Days (long term)

- A student/parent/guardian has the right to appeal a suspension decision to the superintendent (or designee) within 5 days of the initial notice of the suspension. A student/parent/guardian may, alternatively, appeal a suspension decision to the board of education or designated hearing officer within 5 days of the initial notice of the suspension. Either type of appeal must be made in writing, and if no appeal is received the principal's decision is final.
- For appeals to the superintendent, the superintendent will schedule a hearing as soon as possible, notify the student/parent/guardian of the date, time and place of the hearing at

least 24 hours prior to the hearing and notify the student/parent/guardian that they have a right to be present at the hearing. At the hearing, the superintendent will review the facts, determine the guilt or innocence of the student, the reasonableness of the term of the suspension and decide to sustain, rescind, or to modify the suspension. The superintendent will notify the student/parent/guardian of the decision at the conclusion of the hearing. The student/parent/guardian may appeal the superintendent's decision to the board or designated hearing officer within 5 days of the superintendent's decision. The appeal must be made in writing.

- For appeals to the board, the student/parent/guardian must notify the superintendent or board clerk of the appeal request, in writing, within 5 days of the principal's decision or the superintendent's decision.
- The student/parent/guardian will be notified in writing of the date, time and place of the hearing at least 24 hours prior to the hearing. The hearing will be conducted as soon as practical and will be either "open" or "closed" at the student/parent/guardian's option. The student/parent/guardian have a right to be present in person at the hearing. Both the administration and the student/parent/guardian have the right to present evidence and witnesses to support their position and to be represented by legal counsel. The board or hearing officer will determine the guilt or innocence of the student and the reasonableness of the term of the suspension. The board or hearing officer will sustain, rescind or modify the suspension. The board or hearing officer's decision is final and non-appealable.

SPECIAL NOTICE: A disabled student and his/her parent/guardian are entitled to the procedural protection of Section 504 and/or IDEA-B before the student's placement is changed for disciplinary reasons. If additional information is needed, consult the handbook titled, "Discipline of Handicapped Students in Elementary and Secondary Schools," supplied by the U.S. Department of Education, Office for Civil Rights, Washington, D.C. Disabled Students who are disabled and are subject to out-of-school suspension will be afforded the same treatment as provided to students who are not disabled in accordance with Section 504 and its implementing regulations at 24 C.F.R. § 104.4(a), (b) (1) (vii). Specifically, suspension and appeal procedures will be the same as for students who are disabled. These procedures could be altered if the administration makes a determination that the student will be a danger to other students, staff, or school property, or would substantially interfere with the educational process at the school.

Cleveland Public Schools
Suspension Hearing Request or Waiver

Return form to: _____

Student Name: _____

School Site: _____ Grade: _____

☐ I request a hearing related to my child's suspension. I understand that requests are due within 5 calendar days of the suspension or notice of superintendent's decision.

Appeal Hearing

- ☐ My child was suspended for 1-10 days and I want to appeal.
- ☐ My child was suspended more than 10 days and I want to appeal to the superintendent. I might still appeal to the board of education later.
- ☐ My child was suspended more than 10 days and I want to appeal directly to the board of education.
- ☐ My child was suspended more than 10 days, I appealed to the superintendent, and now I want to appeal to the board of education.

Areas of Disagreement

- ☐ At the appeal hearing my child and I will admit the conduct/charges and will only be requesting a reduction in the suspension length or terms.
- ☐ At the appeal hearing my child and I will contest the conduct/charges as well as the length or terms of the suspension.

Representation

- ☐ We won't bring an attorney to the hearing. We understand that the district won't have an attorney either and that if we change our mind we will have to reschedule to allow the school's lawyer to attend too.
- ☐ We will bring an attorney to the hearing. We understand that no attorney is needed. We understand that if we select this option the district will bring its lawyer. Even if we change our mind the district will still use its attorney because the attorney will already be prepared for the hearing.

☐ I waive my right to a hearing related to my child's suspension.

The district will mail notice of the hearing to you at the address on your child's official records. The district can also fax, email, or call you with details if you provide that optional

information here: _____

_____ _____

Parent Name Date

Cleveland Public Schools
Bullying Report Form

Instructions

Complete the form below with as much information as possible. If you need assistance completing this form, contact the district's bullying coordinator, the assistant superintendent. Return the completed form to the assistant superintendent.

Anonymous reports will be investigated to the best of the district's ability, but full information allows the district to conduct a more thorough inquiry. No individual will be retaliated against for filing a good faith bullying report.

Individual Making the Report

Name: _____ Report Date: _____
School: _____ Grade / Job Title: _____
Contact Numbers: _____

Incident Information:

Date of Incident: _____ Time: _____
Location of Incident: _____
Describe Incident: *Use additional pages as necessary, and attach any relevant documents*

_____
_____
_____
_____
_____
_____
_____
_____
_____

Other Witnesses: _____
_____
_____
_____
_____

The information in this report is true and correct to the best of my knowledge. I understand that the district will not tolerate retaliation for filing a good-faith report of bullying. I also understand that if I knowingly file a false report of bullying, I may face disciplinary consequences.

_____ _____
Reporter's Signature Date

Investigation Report

Investigator: _____ Position/Title: _____
Date report received: _____ Date investigation begun: _____

Required Notifications

Date target's parent notified of a report received: _____ Method: _____
Date target's parent notified of completed inquiry: _____ Method: _____
Date bully's parent notified of a substantiated report: _____ Method: _____
Date reported to district's bullying coordinator: _____ Method: _____
Date reported to law enforcement, if applicable: _____ Method: _____

Investigation Process

Individuals interviewed: (attach additional pages if needed)

Name: _____ Date: _____
Interview summary: _____
_____
_____
_____

Name: _____ Date: _____
Interview summary: _____
_____
_____
_____

Name: _____ Date: _____
Interview summary: _____
_____
_____
_____

Name: _____ Date: _____
Interview summary: _____
_____
_____
_____

Name: _____ Date: _____
Interview summary: _____
_____
_____
_____

Documents reviewed: (attach additional pages if needed)
Note: attach copies of all documents reviewed, including witness statements.

Document: _____ Date: _____
Document: _____ Date: _____
Document: _____ Date: _____
Document: _____ Date: _____
Document: _____ Date: _____
Document: _____ Date: _____

Conclusions reached:

_____
_____
_____
_____

Actions taken:

_____
_____
_____
_____

OJA Referral: Yes No

Demographics – Target (or alleged target)

Race	Gender	Disability Status
☐ Hispanic / Latino ☐ American Indian / Alaska Native ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Black or African American ☐ White ☐ Multiracial ☐ Other: _____	☐ Male ☐ Female ☐ Transgender Religion _____	☐ None known ☐ IDEA ☐ 504 Plan English Proficiency ☐ Proficient ☐ LEP

Demographics – Bully (or alleged bully)

Race	Gender	Disability Status
☐ Hispanic / Latino ☐ American Indian / Alaska Native ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Black or African American ☐ White ☐ Multiracial ☐ Other: _____	☐ Male ☐ Female ☐ Transgender Religion _____	☐ None known ☐ IDEA ☐ 504 Plan English Proficiency ☐ Proficient ☐ LEP

Signature of Investigator	Date

Cleveland Public Schools
Student Search Report

Student searched: _____

Date of Search: _____ Approximate time: _____

Person conducting the search: _____

Person witnessing the search: _____

Grounds for reasonable suspicion that the student should be searched: _____

_____

If the search was a vehicle search, why was the vehicle searched? _____

_____

What kinds of items were the object of the search? _____

_____

What was searched (pockets, purse, wallet, coat, vehicle, [if a vehicle search, list areas of vehicle searched] etc.)?

_____

What was found and where? _____

_____

What was done with any items found? _____

_____

_____ _____
Date Person Conducting the Search

_____ _____
Witness Superintendent

Cleveland Public Schools

Parental Authorization to Administer Medicine or Assist with Application of Sunscreen

TO: _____ _____
(Administrator) (School)

I am the parent, guardian or legal custodian with legal custody of _____ _____, a minor student attending this school.

☐ This student requires medication (not including sunscreen) at intervals during the school day. I hereby give my consent and authorize the school nurse, the principal, or _____ (an employee of the School District designated by the school nurse, the principal, and me) to administer:

☐ _____ (name of drug), a non-prescription medication which I am hereby supplying you, in accordance with my written instructions or the written instructions of a physician which are attached hereto.

☐ _____ (name of drug), a filled prescription medication which I am hereby supplying you, in accordance with the directions for the administration of the medicine listed on the label of the vial.

☐ _____ (name of drug), a filled prescription medication which I am hereby supplying you, in accordance with the written instructions of the physician prescribing the medicine, which is attached hereto.

☐ I hereby give my consent and authorize my child to self-medicate under the School District's Policy on the Administration of Medicine to Students.

☐ I desire that the school assist the student in applying sunscreen. I understand that the student may possess and self-apply sunscreen without my written authorization. I hereby give my consent and authorize the school nurse, the principal, or _____ _____ (an employee of the School District designated by the school nurse, the principal, and me) to assist the student in applying sunscreen:

☐ sunscreen, which I am hereby which I am hereby supplying you, in accordance with the label directions.

☐ sunscreen, which I am hereby which I am hereby supplying you, in accordance with written instructions of the student's physician which I have attached.

I understand that under state law the Board of Education, the School District, or employees of the School District shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medicine or assisting in the application of sunscreen I have hereby authorized. I understand that the School District, its agents and employees shall incur no liability for any adverse reaction or injury suffered by the student as a result of

the self-administration of medication and/or using the specialized equipment.

I agree to abide by all of the terms of the School District's Policy on the Administration of Medicine to Students, a copy of which will be given to me on my request.

Date	Signature
Address	Parent with legal custody/guardian

Cleveland Public Schools
Parental Authorization to Administer Seizure Rescue Medication

TO: _____ _____
(Administrator) (School)

I am the parent, guardian or legal custodian with legal custody of _____ _____, a minor student attending this school.

During the school day, this student may require administration of a seizure rescue medication by authorized School District personnel. I hereby give my consent and authorize the school nurse, the principal, or _____ (an employee of the School District designated by the school nurse, the principal, and me) for the _____ school year to administer _____ (name of drug), a seizure rescue medication which I am hereby supplying you in its unopened, sealed package with the label affixed by the dispensing pharmacy intact.

I understand that under state law before a seizure rescue medication can be administered to the student at school, I must do the following:

1. provide the school with this written authorization to administer seizure rescue medication at school;
2. provide the school with a written statement from my child's health care provider that must contain the following information:
   a. the student's name,
   b. the name and purpose of the medication,
   c. the prescribed dosage,
   d. the route of administration,
   e. the frequency that the medication may be administered, and
   f. the circumstances under which the medication may be administered;
3. provide the prescribed medication to the school in its unopened, sealed package with the label affixed by the dispensing pharmacy intact; and
4. collaborate with school personnel to create a seizure action plan.

I understand that under state law employees of the School District shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees taken in compliance with the *Seizure-Safe Schools Act* unless that employee's actions rise to a level of reckless or intentional misconduct. I also understand that under state law, a school nurse shall not be responsible for actions performed by a volunteer.

I agree to abide by all of the terms of the School District's Policy on the Administration of Medicine to Students, a copy of which will be given to me on my request. I also understand my obligations under this policy must be fulfilled before the school can administer a seizure rescue medication to my child and that this written authorization is only valid for the current school year and must be renewed every succeeding school year before seizure rescue medication can be administered to my child at school for that school year.

_____ _____
Date Signature

Address

Parent with legal custody/guardian

Cleveland Public Schools
Statement of Health Care Provider Regarding Administration of
Seizure Rescue Medication at School

To whom it may concern:

Pursuant to the *Seizure-Safe Schools Act*, OKLA. STAT. tit. 70, §1210.183 (2021), before School District personnel may administer a seizure rescue medication to _____, birthdate _____ ("student"), the following information must be provided to the School District by the student's physician.

Please print legibly or type the following information:

1. Student's Name _____;

2. Name and Purpose of the Medication _____
   _____
   _____;
3. Prescribed Dosage _____;
4. Route of Administration _____
   _____;
5. Frequency by which Medication may be Administered _____
   _____; and
6. Circumstances under which Medication may be Administered _____
   _____
   _____
   _____
   _____
   _____

I affirm that I am the student's physician and that the information provided on this form is accurate and was provided by me.

_____

Signature of Physician (or Adult Student) Printed Name & License No.

Cleveland Public Schools

Parent/Guardian Consent and Waiver for Administration of Glucagon

TO: _____ _____

(Administrator) (School)

I am the parent, guardian or legal custodian with legal custody of_____, a minor student attending this school ("Student").

During the school day, the Student may require administration of a glucagon by authorized School District personnel. I hereby give my consent and authorize the school nurse, school employee trained by a health care professional or a school employee who has volunteered and successfully completed training to be a diabetes care assistant for the _____ school year to administer glucagon if the school employee believes in good faith that the Student is experiencing a hypoglycemic emergency or in the event the Student's prescribed glucagon is not available on site or the Student's prescription has expired.

_____hereby releases and waives any and all claims, liabilities or actions, known or unknown, which _____ may ever have against the School District related to employee administration of glucagon to the Student, including, but not limited to, claims under state or federal laws or regulations. _____states that he/she/they understand(s) that this Consent and Waiver clearly and unequivocally releases the School District from liability for its actions and/or negligence, if any, resulting in illness, injury, disability, or death to the Student in any manner during administration of glucagon. I further understand that _____is/are assuming the risk of any illness, injury, disability or death arising from administration of glucagon by a School District employee.

I understand that under state law employees of the School District shall **not** be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees.

I understand that under state law before glucagon can be administered to the student at school, I must do the following:

1. provide the school with this written authorization to administer glucagon at school;
2. collaborate with school personnel to create a diabetes management plan.

I understand that School District employees will call the parent/guardian of the Student and 911 in the event of an emergency, including any time an employee believes my student is experiencing a hypoglycemic emergency.

I agree to abide by all of the terms of the School District's Policy on the Administration of Medicine to Students, a copy of which will be given to me on my request. I also understand my obligations under this policy must be fulfilled before the school can administer glucagon medication to my student and that this written authorization is only valid for the current school year and must be renewed every succeeding school year before seizure rescue medication can be administered to my student at school for that school year.

Date	Signature
Address	Parent with legal custody/guardian

Cleveland Public Schools
Notification of Rights Under the Protection of Pupil Rights Amendment

The Protection of Pupil Rights Amendment affords parents and students who are 18 or emancipated minors ("eligible students") certain rights regarding our conduct of surveys, collection and use of information for marketing purposes, and certain physical exams. These include the right to:

Consent before students are required to submit to a survey that concerns one or more of the following protected areas ("protected information survey") if the survey is funded in whole or in part by a program of the U.S. Department of Education (ED) -

1. Political affiliations;
2. Mental and psychological problems of the student or student's family;
3. Sex behavior or attitudes;
4. Illegal, anti-social, self-incriminating or demeaning behavior;
5. Critical appraisals of others with whom respondents have close family relationships;
6. Legally recognized privileged relationships, such as with lawyers, doctors, or ministers;
7. Religious practices, affiliations, or beliefs of the student or parents; or
8. Income, other than as required by law to determine eligibility.

Receive notice and an opportunity to opt a student out of –

1. Any other protected information survey, regardless of funding;
2. Any non-emergency, invasive physical exam or screening required as a condition of attendance, administered by the school or its agent, and not necessary to protect the immediate health and safety of a student, except for hearing, vision, or scoliosis screenings, or any physical exam or screening permitted or required under State law; and
3. Activities involving collection, disclosure, or use of personal information obtained from students for marketing or to sell or otherwise distribute the information to others.

Inspect, upon request and before administration or use –

1. Protected information surveys of students;
2. Instruments used to collect personal information from students for any of the above marketing, sales, or other distribution purposes; and
3. Instructional material used as part of the educational curriculum.

The School District will develop and adopt policies, in consultation with parents, regarding these rights, as well as arrangements to protect student privacy in the administration of protected surveys and the collection, disclosure, or use of personal information for marketing, sales, or other distribution purposes. The School District will directly notify parents and eligible students of these policies at least annually at the start of each school year and after any substantive changes. The School District will also directly notify parents and eligible students, such as through U.S. Mail or email, at least annually at the start of each school year of the specific or approximate dates of the following activities and provide an

opportunity to opt a student out of participating in:

- Collection, disclosure, or use of personal information for marketing, sales or other distribution.
- Administration of any protected information survey not funded in whole or in part by ED.
- Any non-emergency, invasive physical examination or screening as described above.

Parent/eligible students who believe their rights have been violated may file a complaint with:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, D.C. 20202-4605

Cleveland Public Schools
Athlete Release

To: Athletic Director
Cleveland Public Schools
600 N. Gilbert Street
Cleveland, OK 74020

My signature below certifies the following:

- I am a:
  _____ medical doctor
  _____ doctor of osteopathy
  _____ licensed athletic trainer
  _____ advanced registered nurse practitioner
  _____ physician assistant

  licensed to practice in the State of Oklahoma.

- I evaluated _____ , a student-athlete, on the following date: _____. This occurred after the student-athlete:

  _____ sustained a head injury / suspected concussion
  _____ collapsed or fainted without sustaining a head injury

- If I have evaluated/treated the student athlete for a head injury, I have been trained in the evaluation and management of head concussions.

- It is my professional opinion, based on my training and experience, that the student-athlete named above may return to participation in the district's athletics program on the following date: _____.

_____ _____
Signature of Medical Provider Date

Cleveland Public Schools
Athlete Health Acknowledgments

In compliance with Oklahoma Statute Sections 24-155 and 156 of Title 70, this acknowledgement form confirms that you have read and understand the Concussion/Head Injury Fact Sheet and the Sudden Cardiac Arrest Fact Sheet provided to you by the School District related to these potential adverse health conditions which may occur during participation in athletics.

I, _____ *(please print student-athlete's name)* as a student-athlete who participates in athletics and I, _____ *(please print parent/guardian's name)* as the parent/legal guardian, have read the information material provided to us by the School District related to sudden cardiac arrest and concussions and head injuries occurring during participation in athletic programs and understand the content and warnings.

_____ _____
Signature of Student-Athlete Date

_____ _____
Signature of Parent/Legal Guardian Date

This form should be completed annually prior to the athlete's first practice and/or competition and be kept on file for one year beyond the date of signature in the principal's office or the office designated by the principal.

Concussion/Head Injury Fact Sheet

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump or blow to the head
- Can change the way your brain normally works
- Can occur during practice or games in any sport
- Can happen even if you have not been knocked out
- Can be serious even if you have just been "dinged"

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities like playing video games, working on a computer, studying, driving or exercising. Most people with a concussion get better, but it is important to give your brain time to heal.

What are the symptoms of a concussion?

Signs and symptoms of a concussion can show right up after the injury or may not appear to be noticed until days or weeks after the injury.

Signs Observed by Parents or Guardians

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Cannot recall event prior to hit or fall
- Cannot recall events after hit or fall

Symptoms Reported by Athletes:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness; double or blurry vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy or groggy

What should you, the student athlete, do if you think you have a concussion?

- **Tell your coaches or parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach if one of your teammates may have a concussion.
- **Get a medical checkup**. A doctor or health care professional can tell you if you have a concussion and when you are OK to return to play.
- **Give yourself time to get better**. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Additional concussions can cause damage to your brain. It is important to rest until you get approval from a doctor or health care professional to return to play.

What should parents/guardians do if they think their child has a concussion?

- **Seek medical attention right away**. A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to sports.
- **Keep your child out of play**. Concussions take time to heal. Don't let your child return to play until a health care professional says it's OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a second concussion. Second or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.
- **Tell your child's coach about any recent concussion**. Coaches should know if your child had a recent concussion in ANY sport. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

How can you prevent a concussion?

- Follow the coach's rules for safety and the rules of the sport.
- Practice good sportsmanship.
- Use the proper equipment, including personal protective equipment (such as helmets, padding, shin guards and eye and mouth guards –IN ORDER FOR EQUIPMENT TO PROTECT YOU, it must be the right equipment for the game, position and activity; it must be worn correctly and used every time you play.)
- Learn the signs and symptoms of a concussion

- Concentration or memory problems
- Confusion
- Does not "feel right"

If you think you have a concussion: <u>Don't hide it. Report it. Take time to recover</u>. It's better to miss one game than the whole season.

<u>For more information about concussions visit:</u>

- www.cdc/concussion
- www.cdc.gov/TraumaticBrainInjury
- www.oata.net
- www.ossaa.com
- www.nfhslearn.com

Oklahoma State Department of Health
Creating a State of Health

EDUCATION

Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A student's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues.

SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

While studies have shown sudden cardiac death among young athletes is very uncommon, SCA is the #1 cause of death for student athletes.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- fainting or seizures during exercise;
- unexplained shortness of breath;
- a racing heart;
- dizziness;
- chest pains; or
- extreme fatigue.

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

Can you screen for cardiac abnormalities?

The annual sports preparticipation physical examination includes a personal and family health history to screen for symptoms or warning signs of SCA.

An electrocardiogram (ECG) and echocardiogram (ECHO) are noninvasive and painless options. However, these procedures may be expensive and are not currently advised by the American Academy of Pediatrics and the American College of Cardiology unless the preparticipation examination reveals an indication for these tests.

Senate Bill 239 – The Chase Morris Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to address any sport sanctioned and offered in grades 7 through 12 by a school district in order to keep student-athletes safe while practicing or playing. The requirements of the act are:

- All student-athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.

- Schools may also hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, pediatric cardiologists and athletic trainers.

- In order to coach an athletic activity, coaches are required once each year to complete an approved SCA training course offered by a provider approved by the Oklahoma State Department of Health.

Removal from play/return to play

- Any student who collapses or faints without a concurrent head injury while participating in an athletic activity shall be removed by the coach from participation at that time.

- Any student who is removed or prevented from participating in an athletic activity shall not return to participation until the student is evaluated and cleared for return to participation in writing by a health care provider. Health care provider is defined as a person who is licensed, certified, or otherwise authorized by the laws of this state to practice a health care or healing arts profession or who administers health care in the ordinary course of business (such as a physician, physician assistant, advanced practice nurse, or cardiologist).

Cleveland Public Schools
Food Allergy and Anaphylaxis Plan

Student Information

Name: _____
DOB: _____ ID No.: _____
Grade: _____ Program: _____

Physician Section

The student is allergic to:

_____
_____

A typical reaction for this student is:

_____
_____

I have prescribed the following medication to treat this student's allergy:

_____
_____

The student: ☐ may ☐ may not self-administer this medication.

In case of suspected exposure with no symptoms present take the following action:

_____
_____

In case of confirmed exposure with no symptoms present take the following action:

_____
_____

In case of confirmed exposure with symptoms present take the following action:

_____
_____

Other pertinent information

_____
_____

Physician Address: _____
Physician Phone Number: _____

I affirm that I am a physician licensed to practice medicine in Oklahoma, the student listed above is my patient, and the information on this form is true and correct.

_____ _____
Physician Signature Date

Parent Section

I affirm that my child has been diagnosed with the food allergy identified above by his/her physician. I concur with the instructions outlined above and consent to this treatment for my child. I specifically acknowledge that it is my responsibility to:

- provide any/all medication needed for my child
- ensure the school district has the medications needed for my child
- ensure the school district has the instructions for medications use for my child
- fully cooperate in the development of a new health plan for my child each school year.

I understand that school personnel will use their best efforts to help my child avoid exposure to his/her food allergy but that accidental exposure may still occur. I consent for school personnel to use their best efforts and judgment while assisting my child.

In the event of actual or suspected exposure, in addition to taking the actions outlined above I authorize the following individuals to be contacted, in the order listed:

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____
3. Name: _____ Phone: _____

I acknowledge that this plan is not complete until it has been accepted by the district, as evidenced by the signature of the assistant superintendent, and a copy returned to me for my records.

I have the legal authority to make these decisions.

_____ _____

Parent/Guardian Signature Date

Confirmation Section

This Plan has been finalized between the school district and parent:

_____ _____

Parent/Guardian Signature Date

_____ _____

School Representative Signature Date

Food Allergy and Anaphylaxis Plan Checklist
Internal School Use Only

☐ I have reviewed the attached Plan for student: _____

☐ I have reviewed the attached Plan with the following personnel who will or are likely to have regular interaction with the student:

Employee signature

- classroom teacher: _____
- classroom teacher: _____
- classroom teacher: _____
- classroom teacher: _____
- classroom teacher: _____
- classroom teacher: _____
- classroom teacher: _____
- classroom teacher: _____
- regular substitute: _____
- regular substitute: _____
- coach: _____
- activity sponsor: _____
- cafeteria worker: _____
- cafeteria worker: _____
- cafeteria worker: _____
- cafeteria worker: _____
- cafeteria worker: _____
- cafeteria worker: _____
- a.m. bus driver: _____
- p.m. bus driver: _____
- other transportation: _____
- playground monitor: _____
- classroom aide: _____
- school principal: _____
- office worker: _____
- other: _____
- other: _____
- other: _____
- other: _____

_____ _____

School Nurse Signature Date

Student Activity Release & Permission Form

Event Details

Description: _____
Sponsor: _____

Date: _____
Start Time: _____ End Time: _____

Cost: _____
Items to Bring: _____
Other Info: _____

Transportation

☐ **School vehicles.** The district will provide transportation to/from the event. All students are required to use school transportation to/from the event. The bus will leave from _____ promptly at the start time. Students should arrive_____ minutes in advance to check in. The bus will return as close to the end time as possible. Please arrive promptly to pick up your child from _____.

☐ **Volunteer vehicles.** Parent volunteers will transport students to/from the event in their personal vehicles. Parent vehicles will leave from _____ _____ promptly at the start time. Students should arrive _____ minutes in advance to check in. Parent vehicles will return as close to the end time as possible. Please arrive promptly to pick up your child from _____.

☐ **Personal transportation.** All students are individually responsible for arranging and providing their own transportation to and from the event. The district is not supervising transportation in connection with this event.

Emergency Info

Contacts

Parent/Guardian:_____ #: _____
Name: _____ #: _____
Name: _____ #: _____

Medical

☐ My child does not have any known allergies or other health conditions.
☐ My child has the following known allergies or health conditions:
_____

☐ During this event my child will not need any medication.
☐ During the event my child will need medication. A completed copy of

the district's authorization to administer medication is attached.

Permission

I give permission for my child, _____, to attend the event described above in accordance with the terms outlined in this form. I understand that participation in this event is voluntary and I agree to hold the district and any parent volunteers harmless from liability for their good faith acts connected with this event. In case of emergency, I authorize the event sponsor to obtain medical treatment on behalf of my child. I agree to be financially responsible for those costs.

_____ _____

Parent/Guardian Signature Date

Cleveland Public Schools
Daily COVID-19 School Attendance Questionnaire

In an effort to prevent possible exposure of staff and students to COVID-19, you are requested to review the following questions each morning and PRIOR to your child riding a school bus or entering school.

1. Does your child have a fever of 100 degrees[1] or more?

2. Is your child experiencing (a) a new loss of taste or smell, (b) nausea or vomiting, OR (c) diarrhea?

3. Is your child experiencing two or more of the following symptoms of COVID-19?
    - Chills
    - Cough
    - Fatigue
    - Muscle or body aches
    - Headache
    - Sore throat
    - Congestion or runny nose

4. Is your child experiencing **ANY** of the **Emergency Warning Symptoms** of COVID-19?
    - Shortness of breath or difficulty breathing
    - Persistent pain or pressure in the chest
    - New confusion
    - Inability to wake or stay awake
    - Bluish lips or face

5. Has your child had, or do you think your child has, COVID-19?

6. Has your child tested positive for COVID-19?

7. Has your child been around a person with COVID-19?

If the answer to any of these questions is "YES," **YOUR CHILD SHOULD REMAIN AT HOME** and you should contact the attendance clerk at your child's school by phone or email. Students remaining home as a result of COVID-19 concerns will not be penalized regarding absences. Assignments, tests, or other school work can be made up by arrangement with teachers.

If your child is showing any of the **Emergency Warning Signs** listed in Question 4, **seek emergency medical care immediately**.

If your answer to Question 5, 6, OR 7 is "YES," please contact your physician and the Pawnee County Health Department (918-358-2546) for specific guidance on the criteria to be met before your child returns to school.

[1] This temperature is set per the OSDE *Return to Learn Oklahoma,* June 2020.

By sending your child to school, you are representing to the School District that the answer to each of these questions is "NO."

The Save Women's Sports Act (OKLA. STAT. tit. 70, § 27-106(D)) requires as follows:

> Prior to the beginning of each school year, the parent or legal guardian of a student who competes on a school athletic team shall sign an affidavit acknowledging the biological sex of the student at birth. If the student is eighteen (18) years of age or older, the student who competes on a school athletic team shall sign an affidavit acknowledging his or her biological sex at birth. If there is any change in the status of the biological sex of the student, the affiant shall notify the school within thirty (30) days of such change.

Section 426 of Title 12 of the Oklahoma States provides that "whenever under any law of this state or under any rule, order or requirement made pursuant to the law of this state, any matter is required or permitted to be supported, evidenced, established or proved by the sworn statement, declaration, verification, certificate, oath or affidavit, in writing of the person making the same, the matter may with like force and effect be supported, evidenced, established or proved by the unsworn statement in writing of the person made and signed under penalty of perjury setting forth the date and place of execution and that it is made under the laws of this state."

Cleveland Public Schools
Declaration of Biological Sex at Birth

The undersigned, under the penalties of perjury, declares:

1. _____(Name of Student) participates on a Cleveland Public Schools athletic team.

2. The biological sex at birth of the student named herein was (check one):

   ____Male

   ____Female

3. I further understand Oklahoma law requires me to notify the school within 30 days of any change in status of the biological sex designated above.

4. I state under penalty of perjury under the laws of Oklahoma that the foregoing is true and correct.

   1.

_____ _____

(Date and Place) (Signature)

_____

(Printed Name)