DEEP ROOTS CHARTER SCHOOL

3556 Frankford Avenue, Philadelphia, PA 19134
deeprootscs.org
(267) 399-3727
info@deeprootscs.org

**Congratulations!**

Thank you again for taking this step to become part of the DRCS community and family! We are looking forward to meeting your family and students soon and kicking off our second year in the fall of 2019. Below you will find the packet instructions and next steps for completing the enrollment process. **If you need a paper copy, please stop by the front desk**. Please do not hesitate to reach out if you have any questions!

Kind Regards,
G. Logan Blyler, *Founder and School Leader*

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*The packet consists of the items below. Please make sure to read and complete all forms thoroughly in order to expedite the official registration process. Packets are also available in Spanish, please let us know if you need one.*

Student Registration Packet Contents:

1. This Welcome Letter
2. School Quicks Facts
3. School Year Calendar
4. Student Supplies List
5. Parental Registration Statement *
6. Home Language Survey *
7. Student Information Form *
8. Confidential Health Information Form *
9. School Based Health Center Forms
    a. SBHC Parent Letter
    b. SBHC Medication Authorization Form
    c. SBHC Medical Consent Form
    d. SBHC Dental Consent Form
10. Dismissal Plan Form *
11. Media Consent and Release Form

* These items are required for enrollment.

Student Required Supporting Documents:

***These documents are required prior to your student starting school.***

1. Proof of Child's Age
    a. Examples: Birth Certificate, Baptismal Certificate, Medical Records Listing Date of Birth
2. Two Proofs or Residency
    a. Examples: Lease, Deed, Utility Bill, State ID/License
3. Physical Records (Must be within one year.)
4. Immunization Records (Obtain from physician if you do not have.)

**Our Location:**
Deep Roots Charter School
3556 Frankford Avenue
Philadelphia, PA 19134

**Our Contact:**
Main Office: (267) 399-3727
Fax Number: (267) 491-6550
Email: info@deeprootscs.org

**Important School Times:**
*School Year*: August 26, 2019 – June 19, 2019 ***(K Start August 22, 2018)***
*School Day*: Monday-Thursday: 7:45 AM – 3:30 PM
Friday: 7:45 AM – 1:15 PM (Early Dismissal Every Friday)
*Note: Doors open at 7:45 AM for breakfast. Classes begin at 8:00 AM. Students are considered late at 8:01 AM.*

**Transportation:**
DRCS works with Philadelphia School District yellow vendor school buses according to distance from the school. Students inside 1.5 miles from the school (based on SDP routing software) do not qualify for bus transportation services without an IEP with transportation notes. Also, Kindergarten students do not qualify for bus transportation services without an IEP with transportation notes.

**Specialized Services:**
DRCS operates with full special education services, led by our Director of Specialized Services. We accommodate Individualized Education Programs with multiple program settings and work within our capacity to meet every child's needs.

**Uniforms:**
Uniforms will be available at Cramer's uniforms located at *4533 Frankford Ave in Kensington* and *52nd and Market in West Philadelphia*. We will share additional info about uniforms before the start of school. *We ask that families send an extra pair of uniform pants, underwear, and socks to keep at school in case of a spill or bathroom accident*.

**School Supplies:**
Your student should come to school on the first day with a backpack large enough for a binder and full uniform. We have provided a recommended supplies list in this packet and on our website, but we will also have some supplies at the school if needed.

**Meals:**
Your student will be provided with a breakfast and lunch each day of school. We work with the Archdiocese of Philadelphia NDS program. Alternative meal options are available, and we will do our best to accommodate any allergies your child has. You may also choose to send your child with his or her own breakfast and lunch in a lunchbox with his or her name on it. If providing a breakfast or lunch from home, please be sure meals are healthy, non-snack meals, to be sure your student is sustained during the school day. Students also have the opportunity for a snack during the school day. You should send a snack with your student each day. The snacks MUST be a healthy snack, low in sugar and should be labeled.

# DEEP ROOTS CHARTER SCHOOL

## 2019-2020 School Year Calendar

### JULY 2019

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 | 30 | 31 | | | |

### AUGUST 2019

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | 1 | 2 | 3 |
| 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | 31 |

### SEPTEMBER 2019

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | | | | | |

### OCTOBER 2019

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | 31 | | |

### NOVEMBER 2019

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |

### DECEMBER 2019

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

### JANUARY 2020

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | 31 | |

### FEBRUARY 2020

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | | 1 |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |

### MARCH 2020

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

### APRIL 2020

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |

### MAY 2020

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | | | | | | |

### JUNE 2020

| Su | M | Tu | W | Th | F | S |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 | 30 | | | | |

- Staff Only PD
- Normal Instructional Day
- Early Dismissal for Report Cards (1pm)
- Kindergarten Only Start (Dismissal at 12:30pm)
- Early Dismissal (Every Friday at 2pm)
- PSSA Testing Window (M-F Schedule Applies)
- Early Dismissal (12:30pm)
- End of Quarter
- No School

DEEP ROOTS CHARTER SCHOOL

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# Standard Supplies List

2019-2020

| | Item | Quantity | Note |
|---|---|---|---|
| ☐ | Backpack | 1 | No wheeled backpacks. |
| ☐ | Crayons (24 Count Box) | 4 Boxes | 24 Count Box |
| ☐ | Colored Pencils Pack | 1 Box | 1 Box |
| ☐ | Markers Pack | 2 Boxes | Broad-Tip, Washable |
| ☐ | Binder 1" 3-Ring **(3rd to 5th Only)** | 1 | 1" with Clear Front Pocket |
| ☐ | Pencils #2 | 3 Boxes | Box of 24 |
| ☐ | Scissors | 1 | Blunt-Tip |
| ☐ | Erasers | 1 Pack | 1 Pack or Large Pink |
| ☐ | Paper | 3 Packs | Wide-Ruled Lined Notebook |
| ☐ | Glue Sticks | 10 | May come in packs as well. |
| ☐ | Thin Expo Markers with Eraser | 1 Pack | 1 pack of 24 with an eraser. |
| ☐ | Folders (Plastic) | 10 | Plastic with pockets & prongs.<br>(2 Red, 2 Green, 2 Blue, 2 Orange 2 Purple) |
| ☐ | Composition Books | 1 | 1 Black and White. |
| ☐ | Pencil Pouch with Zipper | 1 | Pouch with Zipper and 3-ring binder holes. |
| ☐ | Dividers with Pocket | 1 Pack | 1 Pack of 8 binder dividers with pocket. |
| ☐ | Disinfectant Wipes **(No Bleach)** | 3 Packs | 50+ in each pack. |
| ☐ | Hand Sanitizer | 3 Bottles | Large Container |
| ☐ | Tissues | 4 Boxes | 4 Standard Boxes |
| ☐ | Extra Set of Clothing | 1 | Clothing in clear bag labeled with child's name. |

*** In addition to this list, you will also need at least 1 extra set of markers, crayons, scissors, and glue to keep at home for homework.**

## Attachment A -Parental Registration Statement

Deep Roots Charter School

Student Name _____

Date of Birth _____ Grade _____

Parent or Guardian Name _____

Address _____

Telephone Number _____

> Pennsylvania School Code §13-1304-A states in part "Prior to admission to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration provide a sworn statement or affirmation stating whether the pupil was previously or is presently suspended or expelled from any public or private school of this Commonwealth or any other state for an action of offense involving a weapon, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property."

Please complete the following:

I hereby swear or affirm that my child was_____ was not _____ previously suspended or expelled , or is _____ is not _____ presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property. I make this statement subject to the penalties of 24 P.S. §13-1304-A(b) and 18 Pa. C.S.A. §4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

If this student has been or is presently suspended or expelled from another school, please complete:

Name of the school from which student was suspended or expelled:

_____

Dates of suspension or expulsion:

_____

(Please provide additional schools and dates of expulsion or suspension on back of this sheet.)

Reason for suspension/expulsion (optional) _____

_____
(Signature of Parent or Guardian)

_____
(Date)

Any willful false statement made above shall be a misdemeanor of the third degree.
This form shall be maintained as part of the student's disciplinary record.

**PENNSYLVANIA DEPARTMENT OF EDUCATION**
**HOME LANGUAGE SURVEY**

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for the identification.

**School District:**_____ **Date:**_____

**School:**_____

**Student's Name:**_____ **Grade:**_____

1. **What is/was the student's first language?** _____

2. **Does the student speak a language(s) other than English?**
   (Do not include languages learned in school.)

   **Yes No**

   **If yes, specify the language(s):** _____

3. **What language(s) is/are spoken in your home?** _____

4. **Has the student attended any United States school in any 3 years during his/her lifetime?**

   **Yes No**

   **If yes, complete the following:**

| **Name of School** | **State** | **Dates Attended** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | ----------_____ | |

_____

**Person completing this form (if other than parent/guardian):**_____

**Parent/Guardian signature:**_____

The school district/charter school/full day AVTS has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school/full day AVTS has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the school district/charter school/full day AVTS may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in the school district/charter school/full day AVTS in the future.

# DEEP ROOTS CHARTER SCHOOL — STUDENT REGISTRATION FORM

PARENT OR GUARDIAN MUST COMPLETE THIS FORM AND PROVIDE ALL NECESSARY DOCUMENTS

**Please Print All**

## STUDENT INFORMATION - SECTION 1

| Last Name | First Name | M.I. | Date of Birth MONTH | DAY | YEAR | STUDENT ID NUMBER |
|---|---|---|---|---|---|---|
| | | | | | | |

| House No. | Dir | Street Name | | | St., Ave., Etc. | Apt# | Zip Code | Phone Number |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

Race Designation: Is this student Hispanic □ Yes or □ No

Gender: □ Male / □ Female

Country of Birth: _____

Home Primary Language _____

Date child first enrolled into a U.S. School _____

**Check all races that apply:**

□ White □ Black / African American □ Native Hawaiian / Other Pacific Islander

□ Asian □ American Indian / Alaska Native

## STUDENT ENROLLMENT HISTORY - SECTION 2

Indicate city and type of school child last attended

□ Philadelphia □ Other City: _____

□ Public School _____

□ Non Public School _____

| Date Last Attended | Grade Last Attended | Name of School | Address | City | State |
|---|---|---|---|---|---|
| | | | | | |

If the student attended school outside of the United States, do you have his/her school records?

□ Yes: If yes, please provide a copy for the school _____

□ No: If no, please contact the school to obtain the records _____

□ Did the child ever attend: □ Pre-Kindergarten and/or □ Kindergarten

| | | | |
|---|---|---|---|
| 1) Has the child ever received Special Education Services in PA or another state? | □ Yes | □ No | If yes, which state: _____ |
| 2) Does your child have a current IEP? | □ Yes | □ No | |
| 3) Does your child have a current evaluation report? | □ Yes | □ No | If yes, what _____ |
| 4) Was the child ever enrolled in an Early Intervention Program? | □ Yes | □ No | |
| 5) Has the child ever received ESOL/Bilingual services? | □ Yes | □ No | If yes, which state: _____ |
| 6) Does your child have a 504 | □ Yes | □ No | |
| 7) Does your child have a Gifted IEP? | □ Yes | □ No | |

## LANGUAGE SURVEY - SECTION 3

| | English | Other | Language |
|---|---|---|---|
| 1) What language does the family speak at home most of the time? | □ | □ | _____ |
| 2) What language does the parent(s) speak to her/his child most of the time? | □ | □ | _____ |
| 3) What language does the child speak to her / his parent(s) most of the time?* | □ | □ | _____ |
| 4) What language does the child speak to her/his brothers/sisters most of the time?* | □ | □ | _____ |
| 5) What language does the child speak to her/his friends most of the time?* | □ | □ | _____ |
| 6) What language does the child speak most frequently?* | □ | □ | _____ |

7) What other languages does the child speak? 1) _____ 2) _____ 3) _____

DEEP ROOTS CHARTER SCHOOL — STUDENT REGISTRATION FORM
PARENT OR GUARDIAN MUST COMPLETE THIS FORM AND PROVIDE ALL NECESSARY DOCUMENTS

## HOUSEHOLD INFORMATION - SECTION 4

**Student Resides With**:

□ Both Parents (same address ) □ Mother □ Father □ Stepparent □ Guardian / Other

| Parent / Guardian Name: | Parent / Guardian Name: |
|---|---|
| (Circle) Mother / Father / Stepparent / Guardian / Other _____ | (Circle) Mother / Father / Stepparent / Guardian / Other _____ |
| (Circle) Male / Female [Active Military] Yes / No | (Circle) Male / Female [Active Military] Yes / No |
| Address: _____ | Address: _____ |
| Phone: _____ (Home) | Phone: _____ (Home) |
| (Cell) _____ | (Cell) _____ |
| (Work) _____ | (Work) _____ |
| Email: _____ | Email: _____ |
| **Preferred Language for School Related Communications:** | **Preferred Language for School Related Communications:** |

## MCKINNEY-VENTO ELIGIBILITY - SECTION 4 *(continued)* *(THIS INFORMATION WILL BE KEPT CONFIDENTIAL)*

Please indicate your current housing status: □Rent □Lease □Own

□ In a motel/hotel due to loss of housing, economic hardship or similar reason
□ Are you currently living with a family member due to loss of housing, economic hardship or similar reason
□ Did you experience a man-made disaster/fire
□ Did you experience an eviction

***If the family is eligible for the Homeless Assistance Act of 1987 (known as McKinney–Vento) please contact your school counselor once registration is completed.***

## SIBLING INFORMATION - SECTION 5

Please list all school aged children (ages 5 and above)

| Name | D.O.B. | Current School | Grade | Student ID# if available |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## EMERGENCY CONTACT INFORMATION - SECTION 6

**** Please list two LOCAL emergency contacts and their relationship to the child in the event a parent or guardian cannot be reached:***

Primary

1) _____ (Name) _____ (Relationship) Gender: Male / Female

_____ (Phone (1)) _____ (Phone (2))

Secondary

2) _____ (Name) _____ (Relationship) Gender: Male / Female

_____ (Phone (1)) _____ (Phone (2))

By signing below, I am allowing Deep Roots Charter School to register my child as a student. I also certify the information provided on this application to be true and accurate and providing false or incomplete information that is required for registration may delay enrollment.

_____ Parent / Guardian Signature _____ Date

_____ Parent / Guardian Signature _____ Date

DEEP ROOTS

# Confidential Student Health Information

**Student Name:** _____
Last First MI

**DOB:** ____ / ____ / _____
mm dd yyyy

**Gender:** M or F **Grade:** _____

## General Information

- The request for identifiable health information will enable us to provide safe and appropriate health care if your child becomes ill or injured at school, on the bus, or during school-sponsored activities. The information that you provide will be maintained confidentially and is limited to individuals that work with your child within the school setting with a legitimate need to know.

**Release of Health Information** (please initial)

| | |
|---|---|
| | Parent **gives** permission to release health information to appropriate school system staff for medical alert notification and health care management. |
| | Parent **prohibits** disclosure of sensitive health information to school staff unless medically necessary without specific request. |

**Parent/Guardian Information** (please print)

| Last Name | First Name | Relationship | Phone #1 | Phone #2 |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Physician Information** (please print)

| Doctor's Name | Clinic/Practice Name and Address |
|---|---|
| Doctor's Phone | Hospital of Choice |
| Insurance Company | Policy/Group # |

**Emergency Contacts** (must be 18 or older) (please print)

| Last Name | First Name | Relationship | Phone #1 | Phone #2 |
|---|---|---|---|---|
| | | | | |
| | | | | |

## Emergency Treatment Release

In the event of an emergency when I cannot be reached, the person named above is authorized to act on my behalf regarding the welfare of my child. I hereby authorize Deep Roots Charter School to transport my child to seek proper medical care. I also authorize the doctor or hospital to treat my child in the event of an emergency.

Signature: _____ Printed Name: _____ Date: _____

*Please Complete Reverse Side*

**Medical History:** Please check all that apply.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | ADHD | | Contact lenses | | Heart problems | | Nosebleeds | | Vomiting |
| | Anemia | | Concussion | | Hemophilia | | Panic attacks | | Procedures: |
| | Anxiety attack | | Cystic fibrosis | | High blood pressure | | Reflux | | Catheterization |
| | Arthritis | | Diabetes | | Hypoglycemia | | Rheumatic fever | | Tube Feeding |
| | Artificial joints | | Depression | | Kidney problems | | Scoliosis | | Equipment: |
| | Artificial valves (heart) | | Dialysis | | Leukemia | | Seizures | | Crutches |
| | Asthma | | Fractures (skull) | | Low blood pressure | | Sickle cell anemia | | Walker |
| | Back problems | | Glasses | | Meningitis | | Sinus problems | | Wheelchair |
| | Broken bones | | Headaches | | Menstrual cramps | | Stroke | | Other: |
| | Cancer | | Hearing problems | | Migraine headache | | Vision problems | | |

Please comment in detail regarding any conditions checked above: _____

_____

_____

_____

**Allergies:** Is your child allergic to any of the following? If so, please list.

| Medications: | Foods: | Insects: | Environmental: | Latex? | Other: |
|---|---|---|---|---|---|
| | | | | Dyes? (Red, Yellow) | |

Does your child require an epinephrine pen for an allergic reaction? ☐ Yes ☐ No

If yes, what type and dose level? _____

Names and dosages of other medications your child takes to treat an allergic reaction:

_____

_____

**Medication:** Please provide information on ALL medication your child takes routinely at home or school.

| Diagnosis for which medicine is given | Name of medication | Form (pill, liquid, inhaler) | Dosage | Specific time(s) to be given | Given at home? | Given at school? |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Parent/Guardian Acknowledgement:** I understand that my child may be allowed to take his/her medication according to the guidelines for Pennsylvania schools for the administrations of medications and emergency care. I also understand that I must personally bring all medications that are deemed medically necessary for administration during the school day to the school and complete a Parent Authorization Form for Administration of Medication. This document will be placed on file in the school office.

I understand that although reasonable attempt will be made to remind the student about medications, it is expected that the student is responsible for obtaining his/her medication if required during the school day.

I agree to indemnify and hold harmless Deep Roots Charter School and its employees from claims relating to the possession or self-administration of asthma inhalers, and understand that Deep Roots Charter School, its employees and agents shall incur no liability as a result of injury to a student or any other person as a result of possession or self-administration of asthma inhalers.

I also authorize the school nurse and district health services staff to consult with the prescribing physician to clarify medication orders, or, in the interest of the student's health, to discuss his/her response to the prescribed medication. All health information will be kept confidential.

Signature: _____ Printed Name: _____ Date: _____

Dear Parents and Caregivers,

We are excited to have you and your student join our Deep Roots Family.

Certain medical records are required by State law and so we can ensure the safety and quality care of your child. We ask that you sign the enclosed consent form and share any chronic health conditions that your child may have so that we may best care for your child while at school.

In partnership with Education Plus Health, Deep Roots Charter School offers a special service for our families to support the overall health & wellness of our students.

You must submit:

1. Health Center Consent Form
2. Copy of Annual Health Physical Exam with up to date Vaccine Records
3. Copy of Dental Visits in the past year
4. Medication Administration Consent Forms for any medications that may need to be given at school.

Your child will need to have this form signed by your child's PCP/Pediatrician. This includes asthma inhalers, epi-pens, diabetic meds, routine medications and intermittent meds. This form is also available at the school health center.

***Student physical, vaccine and dental records MUST be received before your student can begin school.***

We welcome you to visit the health center to learn more about the many health services offered at the school.

Thank you,

G. Logan Blyler,
Founder and School Leader
Deep Roots Charter School

# Request for Administration of Medication or Use of Suction, Oxygen, or Other Equipment

EDUCATION PLUS HEALTH
SCHOOL BASED HEALTH CENTERS

**MEDICAL PROVIDER:** In order for your patient named below to maintain medication at school for administration as ordered and needed, please complete the entire section below, or send the medication order from your Electronic Health Record. Additionally, please accompany the order with the necessary documents below for compliance with PA State Law, School Code Chapter 23, and/or for quality care management by School Based Health Center clinical staff.

This information must be updated annually for each new school year.

_____ Most recent pediatric well-child report INCLUDING vaccine record

_____ Medical Care Plan (Asthma Action Plan, Diabetes, _____)

Please fax this information from your Electronic Health Record or via paper to 267-273-1540. Your practice fax number will be retained for electronic communication on care provided.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Diagnosis: _____

Reason Medication Must Be Given At School: _____

Name of Medication/Equipment/Treatment: _____

Dose: _____ Time/s To Be Given: _____

Total Dosage/24 Hours: _____ Date Begin: _____ Date End: _____

Instructions for Administration/Utilization: _____

_____

Contraindications: _____

Side Effects: _____

Treatment of Side Effects/Actions To Be Taken: _____

Is Any Restriction on Activity Necessary: _____

Is Student Taking Any Other Medication/s (if yes, list): _____

Is Similar Equipment Kept By The Child's Family At Home: _____

## PARENT OR GUARDIAN

To The Principal,

I authorize selected school personnel to administer the indicated medication, or to use the equipment or machinery as prescribed by my child's health care provider, whose signature appears on or accompanies this form.

I authorize the school nurse to communicate with my child's health care provider, and my health care provider to reply, as needed regarding medication/equipment and/or my child's response.

Child's Name: _____

Parent Signature: _____

Parent Telephone Number: _____

Date Signed: _____

---

School policy requires that student medication must be maintained in the health center at all times, students may not carry their medication on them. If you have questions or concerns regarding this policy, please contact the Health Center/Nurse's Office.

I understand that a trained health professional other than the nurse practitioner may administer the medication.

Name of Medical Provider Signing or Authorizing Form:
_____

Practice Name: _____

Phone#: _____

Fax#: _____

Date Signed/Submitted: _____

**School Based Health Center**

**CONSENT FOR HEALTH SERVICES**: I consent to health services provided for my child by the School Nurse Practitioner, other clinicians, and health center staff during the time that the student is enrolled in a school with an Education Plus Health School Based Health Center. I understand that information on primary care provided will be shared with my child's Primary Care Provider for continuity of care. Withdraw of this consent can be done at any time by writing to the School Based Health Center. I recognize that the School Based Health Center will protect my child's health information according to HIPAA, as written below, and that my Medicaid or CHIP health insurance (if applicable) will be billed for clinical services provided with consent.

The School Based Health Center abides by the Federal HIPAA Privacy Rule which gives patients a right to be informed of the privacy practices of health care providers and health plans and of their privacy rights regarding their personal health information. In order to provide care to your child, it may be necessary for the School Based Health Center to use and/or disclose protected health information for purposes of treatment and healthcare operations. Maintaining confidentiality of that information is important to us. The school's Notice of Privacy Practices describes in more detail the uses and disclosures of your protected health information that are necessary, and the obligation to protect that information. You have a right to review the notice before you sign this consent.

In accordance with state and/or federal law, when consent is provided for care, healthcare information is kept confidential and not shared with the school. A few exceptions exist, for example:
- Permission is given by the student/patient or parent/guardian through a signed release of information.
- The patient has a medical condition that the teacher must be informed of to ensure their well-being in the classroom (Need-to-Know)
- The patient has a life-threatening health problem and is under 18 years old.
- There is reason to suspect abuse or neglect; and/or The patient indicates risk of imminent harm to self or others.
- Certain communicable diseases must be reported to public health authorities.

Name of Legal Parent/Guardian: _____ Date: _____

Signature of Guardian:_____ Emergency Contact #:_____

| **Student(s) Name** | **Grade** | **PCP Name & Phone #** | **Insurance Type** (if none, we will contact you to enroll) | **Insurance #** | **Health Concerns** (Illnesses, Allergies, Medications, etc. please list) |
|---|---|---|---|---|---|
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All students will receive universal health screenings by the school nurse as mandated by State law. You will be notified in writing if there are any concerns. **Please submit a copy of your child's physical or dental exam each year, in accordance with State law.**

In the School Based Health Center your child may be able to receive over-the-counter medicine to relieve discomfort (Tylenol, etc) at school. The school nurse will ALWAYS attempt to call you first for permission to administer such medicines. Please list any over-the counter medications you DO NOT wish your child to have._____

**NO PRESCRIPTION MEDICATION can be given at school without an updated consent and medical order every school year.** (Includes asthma inhaler, Epi-pen, ADHD or other medications) Medication kept at the school must be taken home by the parent/guardian at the end of each year and returned at beginning of the next year, with updated medical forms and consents. Please contact the School Based Health Center to receive these forms.

**IMPORTANT ADDITIONAL INFORMATION:** Under PA State law, the School Based Health Center will provide and assist students in accessing outside care if necessary. Under PA State law, youth may independently access reproductive health care at any age without parent/guardian consent (high school only). The School Based Health Center encourages each student to involve his/her parents or guardians in health care decisions whenever possible. When applicable, the School Based Health Center will assist the student in discussing these situations with parents/guardians. Because youth are able to provide consent for treatment, their consent is legally required for release of information about pregnancy and sexually transmitted infections.

# THE DENTIST IS COMING TO YOUR CHILD'S SCHOOL!

## Smile Again Program (SAP) Permission Form

**PLEASE COMPLETE AND SIGN PAGE 2 OF THIS PERMISSION FORM AND SEND IT WITH YOUR CHILD TO SCHOOL TOMORROW**

Smile Again Program, P.C., a Pennsylvania professional corporation ("**SAP**") has partnered with your child's school to assist in dental disease prevention.

If you provide your consent by signing this Permission Form, your child will receive the dental disease prevention services described in the list below (the "**Services**"). A Licensed Dentist and a Registered Dental Hygienist of SAP will see your child at his/her school for two (2) years to allow for continuation of care.

(1) ***If your child has Medicaid or CHIP insurances*** (such as Health Partners, Kidzpartners, Keystone First, United Healthcare Community Plan, Aetna Better Health, Aetna Better Kids, and United Concordia), **there is no cost to you for the Services that your child receives and SAP will bill the insurance program for Services SAP provides for your child**.

(2) ***If your child has private dental insurance***, you may be responsible for any deductibles and/or co-pays required by such private dental insurance and SAP will bill the insurance program for Services SAP provides for your child.

(3) ***No dental insurance?*** *You can sign and return this Permission Form tomorrow WITHOUT your child having dental insurance. If your child has no dental insurance,* **please call PCCY (public citizens for children + youth) at 215-563-5848, extension 17. PCCY may be able to assist you in applying for dental insurance and/or provide you with funds to receive the Services from SAP**.

**By signing this form, I give permission for SAP to provide some or all of the following services for my child:**

- **Complete Dental Exam:** a Licensed Dentist will check your child's teeth
- **Digital X-rays** (taken as needed)
- **Teeth Cleaning:** a Licensed Dentist or Registered Dental Hygienist will clean your child's teeth.
- **Fluoride Treatment:** fluoride is a mineral painted onto every tooth to prevent tooth decay
- **Sealants** (if needed): a thin, clear plastic coating applied to the chewing surfaces of the permanent molars (back teeth) and prevents cavities from forming
- **Oral Health Education:** SAP staff will educate your child on how to properly care for their teeth at home and make good diet choices for a healthy future

SAP will notify you of the Services provided after your child is seen at his/her school. If your child requires additional dental treatment, then SAP will advise you that your child will need to be seen in a dentist's office. If necessary, SAP will assist you in finding a dentist to provide additional dental treatment for your child.

A copy of SAP's Notice of Privacy Practices is attached. This document informs patients about how their protected health information will be shared or kept confidential.

| Student's Last Name: | Student's First Name: | Parent's Email Address: |
|---|---|---|
| Date of Birth: | Age: | Gender: ☐ Male ☐ Female |
| Parent/Guardian Name: | Parent/Guardian Date of Birth and Relationship to Patient: | Home Phone: |
| Address: | City, State, Zip: | Cell Phone: |

## IMPORTANT HEALTH QUESTIONS

Does your child have special needs: ☐ NO ☐ YES If yes, please explain: _____

Chronic or existing medical conditions: ☐ NO ☐ YES If yes, please explain: _____

Current daily medications: _____

Known allergies: ☐ NO ☐ YES If yes, please describe: _____

## INSURANCE INFORMATION

Type of dental insurance? ☐ CHIP ☐ Medicaid ☐ Private Insurance ☐ No Insurance

Dental Insurance Company Name: _____

Member ID #: _____

Child's name as it appears on insurance card: _____

Private Insurance: Name of Insured Adult:_____ Birth Date of Insured Adult _____

Member ID/Policy #:_____ or SSN # _____

Employer Name and Group #: _____

Insurance Phone #: _____

Does your child currently have a dentist? ☐ No ☐ Yes

If yes, what is the name of the practice/dentist? _____

I certify that I have read the contents of this Permission Form and received the Notice of Privacy Practices. I understand that if I need further information or if I have any questions, I can contact the **Smile Again Project Navigator** at smileagainprogram@gmail.com. I believe that I have been given sufficient information to give my consent.

**Parent/Guardian Signature:**

_____ Date:_____

**(MUST HAVE SIGNATURE!)**

School: _____

Grade: _____ Teacher: _____

**Student Dismissal Plan Form**

This document allows us to track who is authorized to pick up your student, and also explicitly names those who are NOT authorized to pick up your student. Please be sure to complete all sections thoroughly, as we WILL NOT release a student to someone who is not authorized.

You can modify this form at any time by visiting our main office. You will need to sign off on the amendment.

*Please include your name on this list as well.

The following people are **authorized** to pick up at dismissal or check out _____ from Deep Roots Charter School.

| Name | Relationship to Child | Phone Number | Amendment Date |
|---|---|---|---|
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The following people are **prohibited** from picking up _____.

| Name | Relationship to Child |
|---|---|
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| | |

☐ My student is authorized to walk home alone or with those listed in the authorized pickup list above.

*Please provide any relevant **documentation** (i.e. court orders).*

Signature: _____ Printed Name: _____ Date: _____

Amendments:

Signature: _____ Printed Name: _____ Date: _____

Signature: _____ Printed Name: _____ Date: _____

Signature: _____ Printed Name: _____ Date: _____

**Student Media Consent and Release Form**

I, as the parent or guardian of _____, hereby give Deep Roots Charter School and its employees, representatives, and authorized media organizations permission to print, photograph, and record my child for use in audio, video, film, or any other electronic, digital and printed media.

a. This is with the understanding that neither Deep Roots Charter School nor its representatives will reproduce said photographs, interview, or likeness for any commercial value or receive monetary gain for use of any reproduction/broadcast of said photograph or likeness. I am also fully aware that I will not receive monetary compensation for my child's participation.
b. I further release Deep Roots Charter School, its Board of Directors, employees, and other representatives from any liabilities, known or unknown, arising out of the use of this policy.

I certify that I have read the Media Consent and Release liability statement and fully understand its terms and conditions.

Name of Child: _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date: _____