INDEPENDENCE HIGH SCHOOL

Information to be typed on IHS Contract

(Please fill out)

Date_____

LAST_____**First**_____**M.I.**_____

STREET_____**Grade:**_____**Sex:**_____

Birth Date:_____ **Age:**_____

CITY:_____**ZIP**_____

PARENT OR GUARDIAN'S NAME:_____

HOME PHONE#_____

EMERGENCY PHONE#_____**(Please list if the emergency # is a cell #, work#, etc and the name of the person who's emergency # you have listed)**

STUDENT'S CELL PHONE#_____

Student's e-mail address_____

Parent's e-mail address_____

Student ID number: _____

If you are 18 years old or will be turning 18 in the school year, please answer the following:

I give my permission for my teacher to contact my parent: Yes____ No____

_____

Signature

HEALTH EMERGENCY INFORMATION-ROSEVILLE JOINT UNION HIGH SCHOOL DISTRICT

Student Last Name_____ First_____ Middle_____

Grade_____ Birth Date_____ Home Phone #_____

If Parent or Guardian cannot be reached, call:
Name/Phone #s: Home/Work/Cell:_____

In the event of an accident or other emergency, I hereby authorize a representative of the school to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation under such circumstances. I further authorize the physician named below or any licensed physician or surgeon to undertake such care and treatment of my child as he/she considers necessary.

I understand that the RJUHSD does not provide accident medical insurance for students for school-related injuries, but does offer student accident insurance for voluntary purchase. Information about student accident insurance is available in the school office.

Insurance Carrier_____Medical Number_____

Physician Name_____Phone_____

The Education Code 49480 requires parents to inform the school when a student has a continuing medication being taken upon a physician's prescription, and authorizes the school nurse to contact the physician with parental consent. See No. 4

Please check the following items if they pertain to your child:

1. **There are no known health problems**. □

2. **Known eye conditions or defect in vision** □ Wear glasses □ Glasses to be worn at all times □
   Contact lenses □ Requires preferential seating □
   Under care of Dr. (name/phone)_____
   Comment_____

3. **Known hearing problem** □ Uses hearing aid □ Presently under care of Dr. (name/phone)_____
   Comment_____

4. Subject to any condition which may result in classroom emergency, such as **Seizures** □ **Fainting Spells** □
   Asthma □ **Allergies** □ **Allergic Reactions to Bee Stings** □ **Heart Condition** □ **ADD/ADHD** □ **Diabetes** □
   Other □ _____
   List Medication prescribed _____Dosage _____for (diagnosis)_____
   Does the drug need to be taken during school hours? Yes □ No □
   Prescribed by Dr. (name/phone)_____

5. Has **physical condition** which limits participation in classroom activities □ **Physical Education** □
   If checked, please explain_____
   Presently under care of Dr. (name/phone)_____

_____Date_____/_____Date_____
Mother's/Guardian's Signature OR Father's /Guardian's Signature

*****Information provided on this emergency card may be shared with school personnel if the information is deemed necessary for the health and well being of the student.**

(Rev. 12-15-09)

FORM A – PARENT/GUARDIAN RECEIPT ACKNOWLEDGEMENT

Pupil's Name _____

School Independence High School Grade_____ Date_____

PART I – *COMPLETION MANDATORY*

ACKNOWLEDGEMENT OF PARENT/GUARDIAN RECEIPT OF ANNUAL PARENT/GUARDIAN NOTICE OF RIGHTS AND RESPONSIBILITIES 2010-11

I hereby acknowledge receipt of the Annual Notification of Parents/Guardians as required by Education Code §48980.

Signature_____

*Parent/Guardian of Pupil Age 17 or Younger **OR** Pupil if Age 18 or Older*

Please do not fill out Part 2 if your student has had HEALTH

PART 2 – *COMPLETION OPTIONAL*

REQUEST FOR NON-PARTICIPATION IN COMPREHENSIVE SEXUAL HEALTH OR HIV/AIDS PREVENTION EDUCATION

I **do not** want my son/daughter named above to participate in (**check appropriate box or boxes):**

- ❒ Comprehensive Sexual Health Education
- ❒ HIV/AIDS Prevention Education

Signature_____

*Parent/Guardian of Pupil Age 17 or Younger **OR** Pupil if Age 18 or Older*

Dear Parents and Guardians:

The purpose of this letter is to inform you about the National School Lunch Program (NSLP). Children need healthy meals to learn. Your child's school offers healthy meals every school day. Depending upon income thresholds determined by the NSLP, families may be eligible for either free or reduced priced meals. We are encouraging all families to review the application to determine if household income meets eligibility guidelines, as income thresholds are adjusted annually. Since other substantial school funding is based on Free/Reduced counts, it is beneficial for families to apply if there is a chance of eligibility. A copy of the application is attached to this correspondence. All families are encouraged to complete. All applications will be confidentially processed by District staff and parents/guardians will be notified of eligibility results.

Families who were eligible last year will have a 30 day grace period (from the first day of school) to re-apply, but ***must re-apply to remain eligible.*** Because processing time is required, families are strongly encouraged to apply well in advance of the grace period deadline, as payment of full meal prices will be required between grace period and approval of renewal applications. Some students are directly certified by the State as eligible for the Free/Reduced program and do not need to complete the application.

If you have any questions about eligibility or completing the application, please contact Nutrition Services at 916-782-5158 and select your child's school of attendance.

Sincerely,

Judy Fischer
Director of Consolidated Programs and Assessment