2026-2027 Pittsburg School Enrollment Form

To be completed each year; also need copy of birth certificate, immunization. social security, CDIB and Soonercare/Medicaid cards on file in school office

First Day at Pittsburg: _____ If new, name of previous school: _____

City & State of school: _____

Students Legal Last Name_____First Name_____Middle Name _____

Alternate or Nickname_____Social Security #_____Birthdate_____

City & State of birth_____Grade_____Gender: Male or Female

Circle Race: 1/African American 2/American Indian 3/Hispanic 4/ Asian 5/Pacific Islander 6/Caucasian-White

If Indian which Tribe: _____Roll # _____Indian from which side family_____

Home mailing address: _____

Directions to Home: _____

Students Cell Phone: _____ Student Email: _____

If student drives to school: Vehicle: Make _____Model _____Tag _____

Medical Problems/Allergies to Foods or Medicine: _____

Vision: No problems Glasses Contacts / **Hearing:** No problems Wears Hearing Aid Other

Student lives with person #1 _____ Relationship: _____

Cell Phone: _____ Employer: _____ Work Phone# _____

Email: _____

Person #2: _____ Relationship: _____

Cell phone: _____ Employer: _____ Work phone# _____

Emergency Contact: _____ Relationship: _____

Phone: _____

List anyone (specifically) who **may not** have contact with your child while at school: _____

A copy of Legal Paperwork needs to be on file in office

Who can pick up this student from school: _____

Photo ID may be requested if person is not known or not listed, a note or call from parent is necessary

Does student ride bus? Yes or No Circle which bus? Rowland Moore Hess/Wood

Circle: Under or Over 1.5 miles / If not bus, rides with _____Relationship: _____

Has student had or currently on an IEP? Yes or No

If so, please circle services: Speech Therapy Learning Disability MR Multi-Handicapped

Other special services: Physical Therapy Other Health Impaired 504 Medical

Occupational Therapy Gifted/Talented

Does student have access to internet at residence? Yes or No

If student participates in sports, circle which ones:

Basketball Softball Baseball Track Golf Cheerleading

Date: _____ Parent/Guardian Signature: _____

Impact Aid Survey Form

The survey date is October 1, 2026

This information is the basis for payment to your school district of federal funds under the Impact Aid Program (Title VII of the Elementary and Secondary Education Act) and may be provided to the U.S. Department of Education if the school district's application for payment is audited. This form must be signed and dated for the school district to receive funds based on this information. All boxes must be filled in with complete information, if applicable.

STUDENT INFORMATION

Student's Last Name	First Name and M.I.	Date of Birth	Grade	School Name	
Home Address (No P.O. Boxes)		City		State	Zip Code
If the student lives on federal property, enter the name of the property.	Name of federal property				

PARENT/GUARDIAN EMPLOYMENT INFORMATION: EMPLOYED ON FEDERAL PROPERTY

Enter information in this section regarding the parent/guardian with whom the student resides if either person was employed on federal property or reported to work on federal property *on the survey date*. Enter the parent/guardian's name as it appears on the employer's payroll record.				
Parent/Guardian's Last Name	First Name and M.I.	Name of Parent/Guardian's Employer		
Name of federal property				
Address of federal property		City	State	Zip Code

PARENT/GUARDIAN EMPLOYMENT INFORMATION: ACTIVE DUTY UNIFORMED SERVICES

Enter information in this section regarding the parent/guardian if either person was *on active duty* in the Uniformed Services *on the survey date*. This does not include members of the National Guard activated for State service under Title 32.			
Parent/Guardian's Last Name	First Name and M.I.	Branch of Service	Rank

PARENT/GUARDIAN EMPLOYMENT INFORMATION: FOREIGN MILITARY

Enter information in this section regarding the parent/guardian if either person was both an accredited foreign government official and a foreign military officer *on the survey date*.			
Parent/Guardian's Last Name	First Name and M.I.	Branch of Service	Rank
Name of Foreign Government			

By signing and dating this form, I am certifying that all typed and written information on this form is accurate and complete as of the survey date.

Signature of Parent/Guardian_____ **Date**_____

Please complete these questions regarding the Impact Aid Survey

Please Circle

1. Parent/Guardian is on Active Military duty Yes No
   If so, which Branch?
   Army Navy Marines National Guard Other _____

2. Parent/Guardian lives on Federal Land? If so, where?
   McAlester Army Ammunition Plant Other _____

3. Parent/Guardian works on Federal Land? If so, where?
   McAlester Army Ammunition Plant Other _____

4. Does child live in Indian Housing? If so, please give **physical** address:
   _____

5. Does child live in Low Rent Housing? If so, please give **physical** address:
   _____

6. Does student have access to internet at residence? Yes No

20____- 20____ **HOME LANGUAGE SURVEY FOR PRE-K-12 SCHOOL DISTRICTS** OKLAHOMA Education

STUDENT INFORMATION

Name of Student: _____ Grade:_____
Last Name First Name Middle Name

Date of Birth: _____ School: _____ Student ID # _____ Gender: Male_____ Female_____
MM/DD/YYYY

Is the student of Hispanic or Latino culture or origin? Yes_____ No_____

Select one or more of the following races:
_____ African American/Black _____ American Indian/Alaskan Native _____ Asian
_____ Native Hawaiian/Pacific Islander _____ Caucasian/White

1. What is the dominant language **most often** spoken by the student? _____
2. What is the language **routinely** spoken in the home, regardless of the language spoken by the student? _____
3. What language was **first** learned by the student? _____
4. Does the parent/guardian need **interpretation** services? Yes ____ No ____ If so, what language? _____
5. Does the parent/guardian need **translated** materials? Yes ____ No ____ If so, what language? _____
6. What was the date the student first enrolled in a school in the United States? _____
MM/YYYY

_____
Date (MM/DD/YYYY) Parent / Guardian Signature

SCHOOL USE ONLY

Please have test score documentation available for the Reading Sufficiency Office to verify.

☐ **Other language than English indicated TWO OR MORE times on questions 1 – 3 above.** The student is classified as "more often" and automatically qualifies as **bilingual** on the accreditation report.

☐ **Other language than English indicated ONLY ONCE on questions 1 – 3 above.** The student is classified as "less often" and only qualifies as **bilingual** on the accreditation report *if* **he or she meets one of the following** (any selection below REQUIRES appropriate documentation):

- ☐ 1. Designated English Learner on one of the Oklahoma English language proficiency assessments: ACCESS for ELLs, Alternate ACCESS for ELLs, WIDA Screener, WIDA MODEL, K-WAPT, W-APT or Oklahoma Pre-K Language Screening Tool (PKST).
- ☐ 2. Scored Basic or Below Basic in ELA on the Oklahoma State Testing Program (OSTP).
- ☐ 3. Scored at or below the 35th percentile (or equivalent) composite reading score on the most recently administered state approved norm-referenced test (NRT). Qualifying score must not pre-date the start of the spring semester of the previous school year.

DOCUMENTATION OF A TEST RESULT FOR STUDENTS MARKED LESS OFTEN

Date(s) of Kindergarten ACCESS, ACCESS for ELLs, or Alternate ACCESS Test	Score(s) on Kindergarten ACCESS, ACCESS for ELLs,or Alternate ACCESS	Date of WIDA Screener or K-WAPT/WAPT or WIDA MODEL	Score(s) on WIDA Screener or K-WAPT/WAPT or WIDA MODEL
	Composite / Overall Score		Composite / Overall Score
	1.		1.
	1.		
	1.		

Date(s) of ELA OSTP	Score(s) on ELA OSTP							
		Below Basic		Basic		Proficient		Advanced
		Below Basic		Basic		Proficient		Advanced
		Below Basic		Basic		Proficient		Advanced

Date of the Oklahoma Pre-K Language Screening Tool	Score on Pre-K Language Screening Tool
	%

Date(s) Norm Reference Test (NRT)	Name of the NRT	Composite / Percentile Score(s)

Question 1: Reference WAVE code 1036
Question 2: Reference WAVE code 1037
Question 3: Reference WAVE code 1038

School Year 2026-2027
Economically Disadvantaged Form

This application should be completed even if your student attends a Community Eligibility Provision or Provision School.

School:_____Grade:_____Student Number: _____

Student Name:_____

Please select the income range that represents the total annual gross income:

- ○ Less than $29,526
- ○ Between $29,526 and $40,034
- ○ Between $40,034 and $50,542
- ○ Between $50,542 and $61,050
- ○ Between $61,050 and $71,558
- ○ Between $71,558 and $82,066
- ○ Between $82,066 and $92,574
- ○ Between $92,574 and $103,082
- ○ Between $103,082 and $113,590
- ○ Between $113,590 and $124,098
- ○ Between $124,098 and $134,606
- ○ Between $134,606 and $145,114

Please select the total number of people in your household:

- ○ One (1)
- ○ Two (2)
- ○ Three (3)
- ○ Four (4)
- ○ Five (5)
- ○ Six (6)
- ○ Seven (7)
- ○ Eight (8)
- ○ Nine (9)
- ○ Ten (10)
- ○ Eleven (11)
- ○ Twelve (12)

Signature: I certify that all information provided on this form is true to the best of my knowledge and that all household income is reported. I understand that this information will impact federal and state funding to the school.

Sign Here:_____**Date:** _____

Print Name: _____

For Office use only:

- ○ Qualified
- ○ Not Qualified

PITTSBURG PUBLIC SCHOOLS

District I-63
Pittsburg, Oklahoma 74560

BOARD OF EDUCATION
VERNA CAUDILL
JIMMY CROSS
KANIMAYA SCHOCK
LINSAY JAMES
MARK PARKER

ADMINISTRATION
CHAD GRAHAM-SUPERINTENDENT
WES WOOD-PRINCIPAL

Dear Parents,

Every year our district participates in a federal funding program called E-Rate. E-Rate offers schools and libraries discounts on certain internet services and network equipment. Because of these discounts, we are able to afford the technology and connectivity that is so critical in educating your children in today's global and technology driven world.

The size of the E-Rate discount is directly related to the number of students that qualify for the Free or Reduced Lunch Program. It is critical that this form be completed by our parents at the time of enrollment as this often sets the budget for up to five years. The local public library also benefits since it shares our discount rate and can get a reduced cost on their internet access and network equipment.

The results of this survey are CONFIDENTIAL. Your name and address will not be shared with anyone, the form will be locked and kept on file in a safe place. Only a total tally will be shared for E-Rate purposes. The income guidelines in the survey are the same as those used for participation in the Free and Reduced Lunch Program. Just know that, since responses to the survey will be kept confidential, answering yes to any of the questions on the attached form will not make your children eligible to receive Free or Reduced-price lunches. Instead, if you have children you would like to enroll in the Free and Reduced Lunch Program, please contact Pittsburg Public School office at 918-432-5062.

Thank you,

E-RATE FY 2026-27 HOUSEHOLD SURVEY
2025-26 School Year

As you prepare for enrollment for the 2025-26 school year, you may want to include an E-rate household income survey in your paperwork. We want to ensure that your school's E-rate discount accurately reflects the income levels of your student population. The enclosed Household Survey letter can be included in your enrollment process to determine income eligibility for your E-rate funding for FY 2026-27.

- Surveys can be used to determine individual student eligibility for NSLP, but survey results cannot be extrapolated. Because the extrapolation of returned surveys is not permitted, NSLP applications can be used as surveys.
- Schools participating in the Community Eligibility Program (CEP) multiply the number of students directly certified by the national multiplier (currently 1.6) to calculate the number of students qualifying for NSLP on the FCC Form 471. Note that this calculation is capped at 100 percent of the student population for the purposes of determining the E-rate discount.
- You can use a combination of methods (e.g., surveys, sibling matches, household eligibility for certain federal programs) to substantiate the eligibility of individual students.

USAC Guidance: Alternative Discount Mechanism

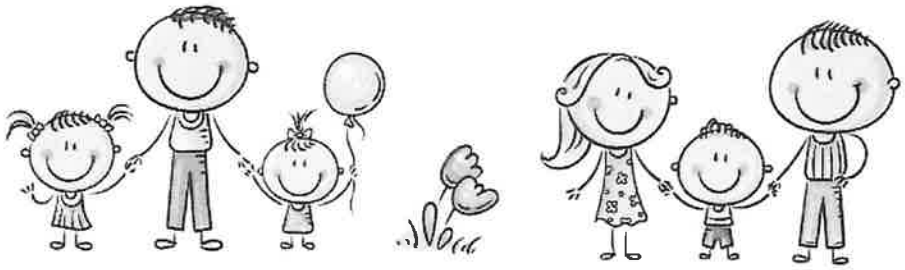
If you decide to use the survey, you will need to tally the results for each eligible site (i.e. ES, MS, HS) - **extrapolation is not allowed by SLD**. Send the summary tally sheets to us when they are completed. We will then submit the summary pages along with your E-Rate application.

Retain the individual surveys and related documentation for 10 years.

SLD Guidelines:

If a school chooses to do a survey, the following guidelines apply:

a. The survey must be sent to families (households) whose children attend the school.
b. The survey must, at a minimum, contain the following information:
    - Address of family (household)
    - Grade level of each child
    - Size of the family (household)
    - Income level of the parents or guardians
c. The survey must assure confidentiality. (Only summary data is provided to USAC/E-rate)
d. Retain ALL surveys for TEN YEARS after the last date of service



Pittsburg Public School
200 West Grand
Pittsburg, OK 74560

July 1, 2026

Dear Parents,

Every year our district participates in a federal funding program called E-Rate. E-Rate offers schools and libraries discounts on certain internet services and network equipment. Because of these discounts, we are able to afford the technology and connectivity that is so critical in educating your children in today's global and technology driven world.

The size of the E-Rate discount is directly related to the number of students that qualify for the Free or Reduced Lunch Program. It is critical that this form be completed by our parents at the time of enrollment as this often sets the budget for up to five years. The local public library also benefits since it shares our discount rate and can get a reduced cost on their internet access and network equipment.

The results of this survey are CONFIDENTIAL. Your name and address will not be shared with anyone, the form will be locked and kept on file in a safe place. Only a total tally will be shared for E-Rate purposes. The income guidelines in the survey are the same as those used for participation in the Free and Reduced Lunch Program. Just know that, since responses to the survey will be kept confidential, answering yes to any of the questions on the attached form will not make your children eligible to receive Free or Reduced-price lunches. Instead, if you have children you would like to enroll in the Free and Reduced Lunch Program, please contact Pittsburg Schools at 918-432-5312

Thank you,

Survey Number: _____
[For School Use Only]

E-Rate Household Survey Spring/Fall 2026[1]

Please complete and return to the school office within two weeks.

Your Address: _____City_____ST_____Zip_____

Circle your household size below, then answer the following questions:

Household Size (Circle One)	Est. Annual Income (As Reported to IRS)	Monthly Income	If Paid Two times per mo.	If Paid Every Two Weeks	Weekly Income
1	$20,345	$1,696	$848	$783	$392
2	$27,495	$2,292	$1,146	$1,058	$529
3	$34,645	$2,888	$1,444	$1,333	$667
4	$41,795	$3,483	$1,742	$1,608	$804
5	$48,945	$4,079	$2,040	$1,883	$942
6	$56,095	$4,675	$2,338	$2,158	$1,079
7	$63,245	$5,271	$2,636	$2,433	$1,217
8	$70,395	$5,867	$2,934	$2,708	$1,354
For each additional family member add	$7,150	$596	$298	$275	$138

Is your income equal to or less than any of the amounts listed next to the number you circled? Yes_____ No_____

Are your children eligible for free or reduced lunches, breakfasts, snacks, or milk at their school(s)? Yes_____ No_____

Is your family eligible for the Supplemental Nutrition Assistance Program (SNAP) – food stamps? Yes_____ No_____

Does your family qualify for medical assistance under Medicaid? Yes_____ No_____

Is your family receiving Supplementary Security Income (SSI)? Yes_____ No_____

Does your family receive housing assistance (section 8)? Yes_____ No_____

Does your family receive home energy assistance (LIHEAP)? Yes_____ No_____

2. **Please list all students in your household that attend school. (Enter the grade they will be entering in this fall. Write on back to list more than 5 students)**

Name	Grade	School Attending in Fall 2025

3. **Certification: I certify that the above information is, to the best of my knowledge, true and complete.**

Signed:_____ Date:_____

[1]Income Eligibility Guidelines for Reduced Priced Meals. Effective from July 1, 2025, through June 30, 2026 (Federal Register/ Vol.90, No. 48/ Thursday, March 13, 2025 / Notices, pg. 11938-39)
Child Nutrition Programs: Income Eligibility Guidelines (2025-2026) | Food and Nutrition Service

OMB Control No. 1810-0021 (Exp. 06/30/2026)

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child _____ Date of Birth _____ Grade level _____

Name of School _____ School District _____

Tribal Membership

The individual with Tribal membership is the (select only one): ○ child ○ child's parent ○ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: _____

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

The Tribe or Band is (select only one):

- ○ Federally Recognized Tribe
- ○ State Recognized Tribe
- ○ Terminated Tribe
- ○ Alaska Native
- ○ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ○ Membership or enrollment number establishing membership (if readily available) or
- ○ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). _____

Attestation Statement
I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Date _____

For Parent/Guardians:

Definitions:
Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

Student Information: Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

Tribal Membership: Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

Attestation Statement: Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

Paperwork Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335

Pittsburg Public Schools
JOM Needs Assessment Survey
2026-2027

1. What do you feel are the main needs of Indian students in our public school system? *(Please indicate by placing a check mark)*

_____ Indian Cultural Programs
_____ Math Improvement
_____ Personal Development
_____ Reading Improvement
_____ Educational Supplies
_____ Indian Studies Programs in the Schools
_____ Career or Job Orientation and Information
_____ Other suggestions: _____
_____
_____

2. Rank the three most important needs in order of priority.
   1. _____
   2. _____
   3. _____

3. How do you think JOM funds could be used to meet the above needs:

_____

_____

_____

4. Please check the category or categories that describe you:

_____ Parent/Guardian
_____ Committee Member
_____ Principal
_____ Teacher
_____ Other
_____ JOM Staff
_____ Elementary Student
_____ JH Student
_____ High School Student

Pittsburg Public School/Student/Parent Compact

The Pittsburg Public School District is committed to the belief that all children can learn and acknowledge that all of us—teachers, administrators, and parents—working together can make a positive difference in student achievement.

Schools Pledge

The school district will provide an optimum learning environment inn which students can experience success and achieve excellence in learning. The school will provide high-quality curriculum and instruction and enable children to meet the state standards. Provide frequent progress reports to parent. Provide reasonable access to staff and provide opportunities for parents to volunteer in the classroom. Each semester, conduct parent-teacher conferences in which the students progress will be discussed.

Parents Pledge (Any adult who is interested in helping this student succeed may sign)

I want my child to achieve educational success. Therefore, I will encourage him/her by doing the following:

_____See that my child is punctual and attends school regularly
_____Support the school in its efforts to maintain proper discipline
_____Establish a time for homework and review it regularly
_____Provide a quiet well-lighted place for study
_____Encourage my child's efforts and be available for questions
_____Stay aware of what my child is learning and his/her progress
_____Read with my child and let my child see me read

Signature _____

Students Pledge

It is important that I work to the best of my ability. Therefore, I shall strive to do the following:

* Attend school regularly
* Come to school each day with pens, pencils, paper, and other tools for learning
* Complete and return all assignments (homework, classwork, projects, etc.)
* Observe regular study hours
* Conform to rules of student conduct

Signature _____

Date _____ Principal's Signature_____

Field Trip Permission

_____ has my permission to go on any school field trips
Students Name
deemed advisable and educational by the Administration of the Pittsburg Schools and the teacher in charge of the trip. It is my understanding that each trip will be carefully chaperoned, whether a walking trip or a trip on which transportation is provided by the school.

Signature of Parent _____
Phone number to be contacted _____

The undersigned parent/guardian hereby specifically authorizes and consents to the furnishing of emergency medical/hospital treatment for the above student of the Pittsburg Public School, while said student is engaged in a school sponsored activity.

Date: _____
Signature_____
Please circle: Parent Guardian

Pittsburg Public School

P. O. Box 200
Pittsburg, Oklahoma 74560
918-432-5062

Internet Access Policy

It is the goal of Pittsburg Public Schools to provide a world-class education to all students. The Internet is one of the many information resources available to students as part of that process. Through the Internet, students can access data from colleges and universities, scientific research facilities, government resources and many other informative sites throughout the world. While there is an enormous amount of useful and valuable information available, due to the global nature of the Internet/Intranet and the lack of effective control over its content, access brings with it the potential for misuse and abuse.

Pittsburg Public Schools will make every reasonable effort to ensure the Internet/Intranet is used responsibility. Pittsburg Public School expects all students to use the Internet in an appropriate and responsible manner for educational purposes only. Access to the Internet/Intranet is a privilege offered to the students at the discretion of the administrators, teachers and library media staff at each school. While at school, students may only log on using the schools Internet account, and may not use personal or home accounts. Students should not attempt to use outside services, hosts or links to bypass filters that are in place for their safety.

Pittsburg Public Schools account is to be used for educational purposes only, including research for projects and intellectual inquiry. Students are not to transmit, receive, submit, publish or otherwise access information deemed inappropriate, including, but not limited to, material that is defamatory, inaccurate, abusive, obscene, profane, racially or gender offensive, unethical, sexually oriented, or illegal. Students will not transmit messages to any cellular phone, Local Area Network computer or Wide Area Network computer that is not part of a school assignment. Students may not use the schools Internet account to conduct private, commercial, personal or illegal business. No activity promoting a political or religious point of view will be permitted. Game playing is prohibited. Hacking, any attempt to gain prohibited access to or malicious attempt to harm or destroy data or to upload, download or otherwise create computer viruses, will not be tolerated. Students are expected to conform to accepted social behavior in their use of the Internet. Users shall refrain from plagiarizing the works of others obtained over the Internet/Intranet and are to respect copyrighted material and to properly credit all works cited from Internet resources.

Students must immediately notify the system administrator if a security problem is discovered. Inappropriate behavior on the part of any student while using Pittsburg Public Schools Internet account may result in the loss of Internet access privileges. Under appropriate circumstances, law enforcement officials may be notified.

Pittsburg Public School system, along with any other persons or organizations associated with the school Internet connectivity, will not be liable for the actions of anyone connecting to the Internet through the school. All users shall assume full liability, legal, financial or otherwise, for their actions while connected to the Internet. In addition, Pittsburg Public Schools takes no responsibility for any information or materials accessed or transferred from the Internet. Parents or guardians agree to accept financial responsibility for any damages or expenses incurred as a result of inappropriate or illegal student activity while using Pittsburg Public School Internet account. Pittsburg Public School system makes no guarantee, implied or otherwise, regarding the validity of information accessed on the Internet, nor does it guarantee protection against corruption of electronic files when information is downloaded. Pittsburg Public School system reserves the right to log network use, monitor files and file space, thus students should not expect their use to remain private. Pittsburg Public School system reserves the right to modify these guidelines at any time.

Internet Access Policy

Please read the following carefully before signing document

Please note that all three boxes must be checked

Both Parent/Guardian and Student must read, sign and return agreement below

Teachers have read and signed the agreement below.

Teachers are responsible for instructing the students on acceptance and proper network etiquette. However, since the student may use the network for individual work or the context of another class, the teacher cannot be held responsible for the student's use of the network.

_____Yes I understand and will abide by the Terms and Conditions for Internet access. I further understand that any violation of the regulations is unethical and may constitute a criminal offense. Should I commit any violations, my access privileges may be revoked, and school disciplinary and/or appropriate legal action may be taken.

_____Yes As the parent/guardian of this student, I have read the terms and conditions for Internet access. I understand that this access is designed for educational purposes and that the Pittsburg Public School District has taken available precautions to eliminate controversial materials. However, I also recognize it is impossible for Pittsburg Public School to restrict access to all controversial materials, and I will not hold the school or Internet provider service responsible for materials acquired on the network. Further, I accept full responsibility for supervision if and when my child use is not in a school setting. I hereby give my permission to grant internet access for my child(ren) and certify that the information contained on this form is correct.

_____Yes I understand that my child's voice, physical presence, and participation in classroom activities may be transmitted to distant learning sites or portrayed on school media. I hereby agree that my child's voice, presence, and participation will not be in violation of his/her rights and herby release any claims for the use of such.

Grade _____

Date Signed _____

_____ _____

Student Printed Name Students Signature

_____ _____

Parent/Guardian Printed Name Parent/Guardian Signature

Pittsburg Public School
918-432-5062
Phones, Wireless Telecommunication Devices, Etc.

Students should not ask teachers or secretaries for permission to make phone calls during class time unless there is an emergency. Students will be called to the phone during class time for emergencies only.

A student may possess wireless telecommunication devise while on school premises, or while in transit under the authority of the school, or while attend any function sponsored or authorized by the school only upon prior written consent of both the student's parent or guardian and the school Principal or Superintendent.

Wireless communication devices are **not to be visible or on, and not to be used on school premises during school or activities without permission of authorized school personnel.**

Any parent, wishing to contact their child, should call their respective principal's office.

Students who violate this policy will be disciplined according to the school's uniform standard or discipline.

I have read the above policy, understand the procedures, and consequences if violated.

(Print Name) Student _____ Grade _____
Date_____
(Print Name) Parent/Guardian _____
Date_____

Permission for Screening

Child's Name: _____ Date of birth: _____
Parent/Guardian's Name: _____
Parent/Guardian's Phone Number(s): _____

I, the parent/guardian of the above-named child, give permission to the licensed speech-language pathologist employed by Pittsburg Public School to screen my child.

_____ (please initial) I understand that this is a free service offered to determine if there is a need for further testing in the areas of speech, language, voice and/or fluency. Pittsburg Public School will provide me with the results of the screening and any recommendations if applicable.

_____ (please initial) I give Pittsburg Public School permission to release this information to persons involved with my child's care.

Please indicate any specific concerns you have regarding your child. Do not hesitate to contact Pittsburg School at (918) 432-5062 if you have any questions.

_____
_____
_____
_____
_____

_____ _____
Parent/Guardian's signature Date

Pittsburg Public School - Medication/Health Permission Form
School Year 2026 - 2027
This form must be completed yearly for medication and health care

Last Name _____ First Name _____

Please circle: Male Female / Grade: _____ DOB _____

Address _____ City _____ Zip _____

Directions to home: _____

_____

Student's Dr. _____ Dentist _____

Mom/Stepmom/Guardian _____ Phone _____

Dad/Stepdad/Guardian _____ Phone _____

Health Information/Allergies _____

Medical Conditions _____

Daily Medications _____

List 2 contacts if parents are not available:

Name _____ Phone _____

Name _____ Phone _____

PARENT/GUARDIAN'S AUTHORIZATION TO ADMINSITER MEDICATION AND HEALTH CARE:

I hereby give permission for my child to receive non-prescription (over-the-counter) medicine and minor medical treatment at school when administered by the school nurse, a school administrator, or a designated school employee for symptomatic relief of minor discomfort and injuries. I give permission for my child to receive short term prescription medicine when sent in by parents.

Mark (X) on each over the counter medication your child may have at school then please sign, date and return to school.

_____ Tylenol (Acetaminophen) _____ Antacids (Tums) _____ Sore Throat Spray

_____ Ibuprofen _____ Cough Drops _____ Generic Benadryl (severe allergic reactions only)

_____ Minor First Aid: Soap & water, sterile wound wash, Carraklenz, hydrogen peroxide, triple antibiotic ointment, burn free gel, aloe vera sunburn gel, generic toothache pain gel, Camphophenique, Bactine, Vaseline, generic caladryl clear, calamine lotion, hydrocortisone cream, anti-itch cream, generic muscle rub, generic sterile eye drops, generic eye allergy relief drops, generic sterile saline solution.

Date: _____ Parent/Guardian Signature: _____

Student Health History

Student's Name: _____

Student's Date of Birth: _____

Does this child have any allergies?	☐Yes	☐No
Does this child need an Epinephrine Injector for allergies?	☐Yes	☐No
Does this child wear a hearing aid?	☐Yes	☐No
Does this child have any special health care needs?	☐Yes	☐No

Does this child have any of the following issues, as diagnosed by an MD?

ADD/ADHD?	☐Yes	☐No	Diabetes Type I or II?	☐Yes	☐No
Anxiety/Depression?	☐Yes	☐No	Hearing or Speech Issue?	☐Yes	☐No
Asthma (requiring an inhaler)?	☐Yes	☐No	Heart Condition?	☐Yes	☐No
Bleeding Disorder?	☐Yes	☐No	Seizures?	☐Yes	☐No
Bladder/Bowel Issues?	☐Yes	☐No	Stomach Issues?	☐Yes	☐No
Cancer?	☐Yes	☐No	Tuberculosis?	☐Yes	☐No
Cystic Fibrosis?	☐Yes	☐No	Vision Problems (Contacts, Glasses, Cataracts)?	☐Yes	☐No
Dental Issues?	☐Yes	☐No			
Other?	☐Yes	☐No			

If you answered "Yes" to any of these questions, please describe the symptoms and treatments used:

What medication does your child take regularly?

Student Health History

What medication will your child take at school?

PLEASE BE ADVISED: A student requiring any over the counter (OTC) or prescription medication at school MUST have a current school year Medication Release form on file. Written physician authorization is REQUIRED for all prescription medications to be given at school. Contact the school for a Medication Release form.

I understand that under state law, the board, the school district, or employees of the district shall NOT be liable to the student or the student's parent(s) or guardian(s) for civil damages for any personal injuries to the student which results from acts or omissions of school employees in administering the medicine I have hereby authorized in the Student Health History online form.

Name of Parent/Guardian with Legal Custody:

Signature of Parent/Guardian with Legal Custody:

Date:

Contact Number of Parent/Guardian:

- -

OSIIS - Authorization to Use or Share Protected Health Information to School or Day Care

Student Name:_____ Demographic/Client ID #:_____
(For School/Day Care receiving PHI to fill out)

Date of Birth:_____

I hereby authorize the Oklahoma Immunization Service to release my Immunization records and information located within the Oklahoma State Immunization Information System ("OSIIS") to: Pittsburg Public School.
(Name of Person/Organization receiving PHI)

The information may be disclosed for the following purpose(s):

☑ to ensure the student meets Oklahoma eligibility requirements for schools/day cares as outlined in Title 70 O.S. § 1210.191 and Oklahoma Administrative Code ("OAC") 310:535-1-2 and OAC 310: 535-1-3

☐ Other: _____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information and revoke this authorization at any time in writing.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- I understand I may change this authorization at any time in writing. However, I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy Regulations.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be **one year** from the date of my signature or upon the occurrence of the following event [*e.g.*, child no longer enrolled in school/day care center] _____.

_____.

X_____ X_____
Signature of Student or Legal Representative Date

_____
Description of Legal Representative's Authority

MEDICINE

Virtual CARE Clinic

School-based behavioral health therapy

What is Virtual CARE?

Oklahoma State University's Center for Health Sciences' ("OSU Medicine") offers individual and/or group counseling services through the Virtual school-based behavioral CARE Clinic. Virtual Counseling Access and Resilience Education (CARE) offers children access to behavioral health services to students within the district while keeping the child in school from a licensed behavioral health professional (Therapist) using a confidential virtual platform.

Virtual CARE therapist work with the child, family, and school staff to develop a collaborative treatment plan, teach effective behavior strategies, treat mental health concerns, and build resilience skills.

What are some services offered?

- Help students dealing with trauma, grief, substance use, peer interactions, and other identified concerns.
- Provide assessment, treatment planning, and interventions for student's behavioral health needs.
- Assist the student in developing healthy coping skills and strategies that build resilience and improve school, home, and social interactions.
- Assist community mental health agencies and responders with crisis intervention and development of safety plans.
- Assist students, educators, and families with mental health and wellness prevention.
- Provide services that are trauma-informed, welcoming, and attentive to the needs of the child, family, and school staff.
- Educate family members and school administration on interventions they can do when responding to behaviors.
- Help students de-escalate when agitated, anxious, angry, or in other vulnerable emotional states.

This service list is not exhaustive, and services can be built per the child's behavioral and mental health needs. OSU Medicine provides various lengths of counseling designed to address varying needs.

The student's first visit will include an intake session in which therapist, student and/or family -assess concerns and develop a plan of care, sometimes called a treatment plan.
If the student (and/or) family and Therapist decide that other services are more appropriate, OSU Medicine will assist you in finding a provider to meet your needs.

Therapists do not prescribe medications. Certain disorders might have medical or biological origins, and, in those cases, the patient should consult a medical provider.

Where do services occur?

Virtual counseling and therapy services take place at school and are provided via Telemedicine on a safe and secure platform that meets state and federal privacy laws.

When can services be accessed?

MEDICINE

OSU Medicine will be available for services **Monday-Friday from 8:00 am to 4:30 pm during the school year** on days that schools are in session and are not an Oklahoma State University Holiday.

If your child is experiencing a mental health crisis outside of these days and hours, call 988 (Oklahoma's Mental Health Lifeline).

Why services can be beneficial?

OSU Virtual Therapist work with the student to build a therapeutic relationship that supports treatment and care goals. It can be scary to discuss uncomfortable emotions, stressful situations, and traumatic events but counseling and therapy can help children work through difficulties and develop healthy skills to cope and increase resilience. Some of the benefits of virtual school-based therapy include:

- Appointments occur at school so the child isn't counted absent.
- Family can connect with therapist through the virtual platform and don't have to leave work or home.
- Supports improved behaviors at school.
- Students gain coping skills to use in school and at home.
- Therapist works with the child and members of the child's school and family to create solutions.

Who can participate?

Any student in the school can participate based on need and availability. There will be no payment from the patient or their parents/legal guardians for the provision of these services and no insurance is needed.

If you would like to learn more about virtual school-based therapy or think your child could benefit from school-based behavioral therapy, please return and a member of the OSU Virtual school-based therapy team will be in contact with you. Services can be accessed during the school year.

___Yes, I would like to talk with an OSU Virtual Therapist about my child receiving services.

Phone:_____Email:_____

Name:_____

Relationship to Child:_____

Virtual Quick Care Clinic
Informed Consent

WHAT IS QUICK CARE?

Oklahoma State University Center for Health Sciences' ("OSU Medicine") Virtual Quick Care can offer convenient basic medical care to students within the district without appointments and with the convenience of keeping the child in the school. It also allows the student to remain at school and the parent or parents to get virtual notification of the need for evaluation but remain in their place of employment. Quick Care concentrates on non-life-threatening health conditions like common illnesses or minor injuries.

The clinic will be staffed by Advanced Practice Practitioners ("Healthcare Provider") that can provide basic medical care to the students and certain prescriptions to a local pharmacy, if needed. The OSU Medicine Healthcare Provider team consists of Licensed Physicians, Nurse Practitioners, Physician Assistants, and Medical Residents. The Healthcare Provider will triage a student to determine if a higher level of care such as urgent care or an emergency room visit is needed.

Quick Care is limited to minor health situations and if comprehensive lab testing or imaging is needed, the student will be referred to the appropriate level of care.

What are the common complaints that can be treated?

Cold and flu symptoms	Pink eye
Insect Bites	Allergies
Rashes	Diarrhea
Earaches/ Ear Infections	Cough
Sore throat	Mild to moderate fevers
Nausea, vomiting, abdominal pain	Skin Infection

What are the common complaints that cannot be treated?

Fractures or suspected fractures	Weakness
Lacerations or large open cuts	Extreme Difficulty Breathing
High fevers	Urinary Tract Infection
Chest pain	Allergic Reactions
Stroke like symptoms	Pneumonia

VIRTUAL SERVICES

The Quick Care service will be provided via Telemedicine on a safe and secure platform that meets state and federal privacy laws.

INDEPENDENT CONTRACTOR

OSU Medicine serves as an independent contractor for the provision of certain medical services on behalf of the school district and is not a district employee.

BUSINESS HOURS

OSU Medicine will be available for services Monday-Friday from 8:00 am to 4:30 pm during the school year on days that schools are in session and are not an Oklahoma State University Holiday. OSU Medicine will also be available for services during Summer School hours during designated times as agreed upon with the School District.

If you are experiencing a life-threatening medical emergency outside of these days and hours, please call 911 or have someone take you to the nearest emergency room for help.

If you are experiencing a mental health crisis outside of these days and hours, please call 988 (Oklahoma's Mental Health Lifeline).

RISKS AND BENEFITS

Your Healthcare Provider will discuss the potential risks and benefits of your proposed treatment plan with your during your appointment, including the risks and benefits of non-treatment.

PROVIDER/PATIENT RELATIONSHIP

Patients and Therapists have a professional relationship existing exclusively for treatment.

PATIENT'S RIGHTS

Patients receiving services from OSU Medicine have the following rights:

1) To be treated with respect and dignity;
2) To receive quality treatment regardless of race, religion, ethnic origin, national origin, evidence of insurability, sexual orientation, age, disability, or medical condition.
3) To be provided confidentiality and protected from any unwarranted disclosure;
4) To be involved in planning treatment;
5) To refuse treatment to the extent permitted by law and to be informed of the possible consequences of your actions; and
6) To expect continuity of care.

PAYMENT

There will be no payment from the patient or their parents/legal guardians for the provision

of these services.

EMERGENCIES

If you are experiencing a life-threatening medical emergency, call 911 or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY

Discussions with a Care Provider are confidential. No information will be released without your written consent unless required by law. Possible exceptions include, but are not limited to:

- Abuse, neglect and/or sexual exploitation;
- AIDS/HIV infection and possible transmission;
- Criminal prosecutions;
- Child Custody cases;
- A negligence suit brought by the Patient against the Care Provider; or
- The filing of a complaint with the licensing or certifying board.

CONSENT TO TRANSMIT RECORDS TO PRIMARY CARE PHYSICIAN

To ensure that your medical record is complete, it is important that we are able to transmit records of any care you received from us to your primary care physician so that they are updated on your health.

By signing below, you as the Patient/Decision-maker of said patient are consenting to the release of any records of the care you received from our Quick Care Clinic to your primary care physician.

_____

Primary Care Physician name, phone number, fax number

_____ _____

Signature of Patient or Parent/Legal Guardian

Printed Name of Patient or Parent/Legal Guardian

Relationship to Patient: ___Parent ___Legal Guardian

___Durable Power of Attorney ___Other/Relationship:_____

Date (Month/Day/Year): _____/_____/_____

CONSENT TO TREATMENT

As the Patient/Decision-maker of said Patient, I acknowledge reading, understanding, and agreeing to the information in this form. I have had the opportunity to address questions or request clarification for anything that is unclear. I am voluntarily agreeing to receiving treatment for me (or my child), and I understand that I may stop such treatment at any time.

I also acknowledge that this consent will be valid for the entire school year, unless it is revoked earlier, and the OSU Medicine Healthcare Provider may see the patient without the parent on site.

_____ _____

Signature of Patient or Parent/Legal Guardian

Printed Name of Patient or Parent/Legal Guardian

Relationship to Patient: ___Parent ___Legal Guardian

___Durable Power of Attorney ___Other/Relationship:_____

Date (Month/Day/Year): _____/_____/_____

Virtual School-based Therapy
Informed Consent

WHAT IS VIRTUAL CARE?

Oklahoma State University's Center for Health Sciences' ("OSU Medicine") offers individual and/or group counseling services through the Virtual school-based behavioral CARE Clinic. Virtual **C**ounseling **A**ccess and **R**esilience **E**ducation (CARE) offers children access to behavioral health services to students within the district while keeping the child in school from a licensed behavioral health professional (Therapist) using a confidential virtual platform.

Virtual CARE therapist work with the child, family, and school staff to develop a collaborative treatment plan, teach effective behavior strategies, treat mental health concerns, and build resilience skills.

WHAT ARE SOME SERVICES OFFERED?

- Help students dealing with trauma, grief, substance use, peer interactions and other identified concerns.
- Provide treatment planning and interventions for student's behavioral health needs.
- Educate students on healthy behaviors that increase ability to deal with difficult situations.
- Assist community mental health agencies and responders with crisis intervention and development of safety plans.
- Assist students, educators and families with mental health and wellness prevention.
- Provide services that are trauma-informed, welcoming and attentive to the needs of the child, family, and school staff.
- Educate family members and school administration on interventions they can do when responding to behaviors.
- Help students de-escalate when agitated, anxious, angry or in other vulnerable emotional states.

This service list is not exhaustive, and services can be built per the child's behavioral and mental health needs.

Therapists do not prescribe medications. Certain disorders might have medical or biological origins, and, in those cases, the patient should consult a medical provider.

VIRTUAL SERVICES

The counseling services will be provided via Telemedicine on a safe and secure platform that meets state and federal privacy laws.

INDEPENDENT CONTRACTOR

OSU Medicine serves as an independent contractor for the provision of certain medical and behavioral services on behalf of the school district and is not a district employee.

BUSINESS HOURS

OSU Medicine will be available for services Monday-Friday from 8:00 am to 4:30 pm during the school year on days that schools are in session and are not an Oklahoma State University Holiday. OSU Medicine will also be available for services during Summer School hours during designated times as agreed upon with the School District.

If you are experiencing a life-threatening medical emergency outside of these days and hours, please call 911 or have someone take you to the nearest emergency room for help.

If you are experiencing a mental health crisis outside of these days and hours, call 988 (Oklahoma's Mental Health Lifeline).

COUNSELING

OSU Medicine provides various lengths of counseling designed to address varying needs. The first visit will include an intake session in which the therapist, student and/or family assess concerns and develop a plan of care, sometimes called a treatment plan.

If the client (or) family and Therapist decide other services are more appropriate, OSU Medicine will assist the client and family in finding a provider to meet their needs.

RISKS AND BENEFITS

Counseling and therapy are beneficial, but as with any treatment, there are inherent risks. During counseling, discussions about personal issues may bring uncomfortable emotions such as anger, guilt, and sadness. Therapist work with the patient to build a therapeutic relationship that supports treatment and care goals. Benefits of virtual school-based therapy include:

- Appointments occur at school
- Family can connect with therapist through the virtual platform and don't have to leave work or home
- Supports improved behaviors at school
- Students gain coping skills to use in school and at home
- Work with members of the child's school and family to create solutions

CLIENT/THERAPIST RELATIONSHIP

Client and Therapists have a professional relationship existing exclusively for treatment.

CLIENT RIGHTS

Clients receiving services from OSU Medicine have the following rights:

1) To be treated with respect and dignity;
2) To receive quality treatment regardless of race, religion, ethnic origin, national origin, evidence of insurability, sexual orientation, age, disability, or medical condition.
3) To be provided confidentiality and protected from any unwarranted disclosure;
4) To be involved in planning treatment;
5) To refuse treatment to the extent permitted by law and to be informed of the possible consequences of your actions; and
6) To expect continuity of care.

PAYMENT

There will be no payment from the client or their parents/legal guardians for the provision of these services and no insurance is needed.

EMERGENCIES

If you are experiencing a life-threatening medical emergency, call 911 or have someone take you to the nearest emergency room for help.

If your child is experiencing a mental health crisis, call 988 (Oklahoma's Mental Health Lifeline).

CONFIDENTIALITY

Discussions with Providers are confidential. No information will be released without your written consent unless required by law. Possible exceptions include, but are not limited to:

- Abuse, neglect and/or sexual exploitation;
- Criminal prosecutions;
- Child Custody cases;
- Suits in which the mental health of a party is at issue;
- A negligence suit brought by the Patient against the Care Provider; or
- The filing of a complaint with the licensing or certifying board.

OSU | MEDICINE

DUTY TO WARN/DUTY TO PROTECT

Under certain circumstances, OSU Medicine may have a duty to warn/protect the child or public. OSU Medicine Therapists rely on education and experience, in addition to state/federal law and regulations when making determinations.

CONSENT TO TREATMENT

As the Client/Decision-maker of said Client, I acknowledge reading, understanding, and agreeing to the information in this form. I have had the opportunity to address questions or request clarification for anything that is unclear. I am voluntarily agreeing to receiving treatment for me (or my child), and I understand that I may stop such treatment at any time.

I also acknowledge that this consent will be valid for the entire school year, unless it is revoked earlier, and the OSU Medicine Therapist may see the patient without the parent on site.

_____ _____

Signature of Patient or Parent/Legal Guardian

Printed Name of Patient or Parent/Legal Guardian

Relationship to Patient: ___Parent ___Legal Guardian

___Durable Power of Attorney _Other/Relationship:_____

Date (Month/Day/Year): _____/_____/_____

MEDICINE

Patient Registration Form

PATIENT DEMOGRAPHICS

Patient name:_____ SSN:_____

Sex assigned at birth: ☐Male ☐Female Birthdate:_____

Permanent address:_____ Home phone:_____Primary? ☐

City:_____State:_____Zip:_____ Cell phone:_____Primary? ☐

E-mail:_____

Language:_____ Interpreter needed? ☐Yes ☐No

Ethnicity: ☐Hispanic ☐Not Hispanic

Race: ☐American Indian/Alaska Native ☐Asian ☐Black or African American

☐Caucasian ☐Hispanic ☐Native Hawaiian ☐Other

PRIMARY CARE PROVIDER (PCP) INFORMATION – WHO IS YOUR PRIMARY CARE DOCTOR?

PCP:_____ PCP Phone:_____

PREFERRED PHARMACY

Pharmacy:_____ Number:_____

Address:_____

EMERGENCY CONTACT

Name:_____Home phone:_____Primary? ☐

Relationship:_____Work phone:_____Primary? ☐

Legal guardian? ☐Yes ☐No Cell phone:_____Primary? ☐

Please Complete Medical History on the Back Side of This Form

Patient Name _____ Date _____

Past Medical History

Please check any condition you have or have had. ☐No medical history to report

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Blood transfusion
☐ Cancer
☐ Congestive Heart Failure
☐ Nerve/Muscle Disease
☐

Lung disease
☐ Meningitis
☐ Depression
☐ HIV/AIDS
☐ Kidney Disease
☐ Diabetes mellitus
☐ Clotting Disorder (blood clot)
☐ High Blood Pressure
☐

Acid Reflux
☐ Glaucoma
☐ Gout
☐ Heart Attack
☐ High Cholesterol
☐ Osteoporosis
☐ Seizures
☐ Sickle Cell Anemia
☐

Stroke
☐ Substance Abuse
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers
☐ Anesthetic Complications
☐ Cataracts
☐ Other: _____

Past Surgical History

Please check any surgery you have had. ☐Never had surgery

☐ Appendix
☐ Brain Surgery
☐ Breast Surgery
☐ Open Heart or Bypass Surgery
☐ Gall Bladder

Colon Surgery
☐ Fracture Surgery
☐ Hernia Repair
☐ C-Section
☐ Eye Surgery

Hysterectomy
☐ Joint Replacement
☐ Small Intestine Surgery
☐ Spine Surgery
☐ Tubes Tied

Heart Valve Replacement
☐ Cosmetic Surgery
☐ Orthopaedic Surgery _____
☐ Other: _____

Social History

Please check all that apply

☐ Current Every Day Smoker
☐

☐ Never Smoker
☐

☐ Alcohol: Drinks/week
☐

☐ Drug use: Uses/week _____

☐ Current Some Day Smoker
☐ Former Smoker
Quite Date _____
☐

Passive Smoker (2nd Hand Smoke)

☐ Vaping

_____Glasses of wine
_____Cans of Beer
_____Shots of Liquor
_____Drinks containing 0.5oz of alcohol

☐

Marijuana
☐ Cocaine
☐ Methamphetamines
☐ IV

Family Medical History

Please write in any medical condition or disease that has been in your family

Disease	Family Member(s)		Disease	Family Member(s)

Current Medications ☐No medications

Medication	Strength	How Often?

Medication Allergies ☐No known medication allergies

Medication	Reaction		Medication	Reaction