APPLICATION FOR ADMISSION

International Student

OAK GROVE LUTHERAN SCHOOL

INTERNATIONAL STUDENT APPLICATION FOR ADMISSION

Name of Applicant: _____

Home City: _____ Country of Citizenship: _____

Sex: Male ____ Female ____ Country of Birth: _____

Applying for School Year 201____ - 201____

Applying for Grade:
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12

Student Photo

Program Type Applying for:
- ☐ School Year (1 Year Cultural Exchange)
- ☐ Semester
- ☐ One Year
- ☐ Diploma Seeking

Associated with/Partnered with (organization): _____

How did you hear about us? _____

Deadline for submitting application is May 1, 2017

International Student Office of Admissions

124 North Terrace
Fargo, North Dakota 58102-3899 U.S.A.
Phone: 701.373.7157 • FAX: 701.297.1993
lisa.nicholas@oakgrovelutheran.com
www.oakgrovelutheran.com

Date application received by OGLS
_____
Non-refundable application fee included
_____

Application Procedure & Timetable

STEP 1

USE APPLICATION CHECKLIST (Included in Application Packet)

- ☐ Complete Application
- ☐ Include 1 - Principal/Headmaster Recommendation
- ☐ Include 2 - Teacher/Advisor/Class Master Recommendation Forms
- ☐ Official Transcripts must be submitted with application and translated into English on the Oak Grove's Grades & Attendance Form
- ☐ Complete Medical Information Form
- ☐ Complete Student Health Form
- ☐ Complete Certificate Immunization Form* by Physician
- ☐ Complete Sports Physical Form by Physician
- ☐ Complete Computer Use Form
- ☐ Include application fee of $150 - US Currency (non-refundable)
- ☐ Skype Interview

*** Document is required by law and must be completed and submitted with application.**

STEP 2

IF STUDENT IS ACCEPTED, Oak Grove will send the following:

- ☐ The Acceptance Letter
- ☐ The Letter of Support
- ☐ The I-20 Form from Oak Grove Lutheran School
- ☐ International Student Handbook (some forms to be signed by natural parents)
- ☐ A receipt for the application fee

STEP 3

VISA APPLICATION. The documents needed at the Embassy are:

- ☐ The Passport
- ☐ The Acceptance Letter and Letter of Support
- ☐ The I-20 Form issued from Oak Grove Lutheran School
- ☐ The receipts for any payments made
- ☐ Proof of family financial support
- ☐ Proof of connections to home country after schooling is finished

STEP 4

WHEN VISA IS GRANTED:

- ☐ Inform the Admissions Department of Oak Grove Lutheran School
- ☐ Inform the Admissions Department of Flight and Arrival Arrangements*

***International Students must arrive during designated dates outlined in the Acceptance Letter.**

STEP 5

PROOF OF MEDICAL/HEALTH INSURANCE
*** PAYMENT DEADLINE FOR REMAINING FEES: AUGUST 1 ***

STEP 6

Departure to Fargo

Application Checklist

_____APPLICATION FORM AND FEE:

Return the completed form with a $150 non-refundable application fee.
(PAYABLE IN U.S. CURRENCY)
For wire transfer, please e-mail Michael Thompson at michael.thompson@oakgrovelutheran.com.

_____TRANSCRIPT(S):

A transcript of your courses, credits and grades from any schools attended are very important to our review process. Transcripts from the past three (3) years of school are required. **These transcripts must be official, bear official seals, be for 3 years prior to grade applying for admission at Oak Grove and be translated into English on our Oak Grove Grade and Attendance Form found in the application packet or online.**.

_____RECOMMENDATIONS:

Information from your principal and two teachers will be used for admissions and placement decisions. All forms must be returned with your application. **Recommendations must be completed in English**.

_____TESTING:

A Secondary Level English Placement (SLEP) test is required with your application.
A minimum score of 50 is required.

_____IMMUNIZATIONS:

The Immunization and Physical Examination Form is required by law and must be submitted with your application. Students are not allowed to begin the school year if their immunizations are not up-to-date. **This form must be completed in English, signed and stamped by the physician.** Students arriving with immunization records not up-to-date will be required to obtain necessary immunizations at their own expense prior to starting school.

_____SPORTS PHYSCIAL FORMS:

The NDHSAA Participation Physical Evaluation Form must be completed with page 1 being filled out by parent/student and page 3 & 4 being filled out by the physician. This form must be completed in English, signed and stamped by the physician and returned to Oak Grove upon arrival.

_____COMPUTER USE FORMS:

Must be read and signed by student and natural parent and returned to Oak Grove to allow the student access to school computers.

_____PROOF OF MEDICAL INSURANCE: Must be provided prior to arrival in the U.S.

_____INTERVIEWS:

A SKYPE (on-line) interview must be completed prior to being accepted into the international program.

Send Completed Application to: **International Student Admissions Department**
Oak Grove Lutheran School
124 North Terrace
Fargo, ND 58102 USA

Personal Information *Please fill in ALL spaces in English unless directed otherwise.*

Name of Applicant:

Family name (as appears on passport) **Family name** (in native language) **First name** (as appears on passport) **First name** (in native language)

Middle name (as appears on passport) **Middle name** (in native language)

Address:_____ State/Province/Territory: _____

City:_____ Country:_____ Postal Code:_____

Address in Native Language (if different than English):_____

English nickname (if applicable):_____ Applicant's Telephone: _____

Applicant's E-mail:_____ Age: _____ Date of Birth: ____/_____/ _____

Height (in inches):_____ Weight (in pounds): _____ Eye Color: _____

_____ Native Language _____ Religion: _____

Sex: Male ___ Female ___ Passport Number:_____ Type of Visa held (if any or applying for):_____

Do you have any health problems? (this will not affect your acceptance to this school) _____

_____

_____

_____

Family Information *Please fill in ALL spaces in English unless directed otherwise.*

FATHER:

Father's Name: _____ (in native language)_____

Address (if different from applicant's): _____

Address (in native language): _____

Telephone:_____ Fax:_____ Work Telephone: _____

E-mail:_____ Age:_____

Occupation and Title:_____ Company Name: _____

MOTHER:

Mother's Name: _____ (in native language): _____

Address (if different from applicant's): _____

Address (in native language): _____

Telephone:_____ Fax:_____ Work Telephone: _____

E-mail:_____ Age:_____

Occupation and Title:_____ Company Name: _____

SIBLINGS:

Brother/Sister Name: _____ Age:_____

Brother/Sister Name: _____ Age:_____

Brother/Sister Name: _____ Age:_____

School Information *Please fill in ALL spaces in English unless directed otherwise.*

Applicant's Current School: _____

School Address:_____ State/Province/Territory: _____

City:_____ Country:_____ Postal Code:_____

Telephone Number:_____ Date entered:_____ Is school: public? _____ private?_____

Current Grade Level: _____ Out of Total Number of Grades: _____

Current GPA:_____ Last Year's GPA: _____

GPA = Grade Point Average

Student's Life

Responses must be completed full and in English.

1. What sports/activities are you active in? _____
   _____

2. Have you taken the TOEFL JR. test? Yes_____ No_____. Have you taken the SLEP test? Yes_____ No_____.

   If yes: Date taken:_____ Score:_____ ***If yes***: Date taken:_____ Score:_____

3. What do you plan to do after you finish high school? _____
   _____
   _____

4. To whom should correspondence (grade reports, communications, etc.) be sent?
   _____Parents - address listed on page 2.
   _____School _____Associated Agency
   To the attention of: (in English)_____

   (in native language) _____

   Title _____ E-mail:_____

   Telephone:_____ Fax: _____

5. Emergency contacts **other than parents**:
   In Home Country
   Name: _____ Relationship: _____
   Telephone:_____ Fax:_____ E-mail: _____
   Do they understand and speak English? Yes_____ No_____

   In the U.S.A.
   Name: _____ Relationship: _____
   Telephone:_____ Fax:_____ E-mail: _____

6. Are you religiously: ☐Very Active ☐Active ☐Inactive

In 3-5 sentences, please answer the following scenarios:

- You decide one day you want to study/do something your parents are not wanting you to do. You are very passionate about doing this but they disagree. Explain how you deal with this conflict with your parents.
- After studying at Oak Grove for one month, you realize that you don't seem to understand the subject material, your English is not as good as you where hoping it was, and your grades begin to drop. Explain what you would do to better your situation.
- What do you plan to be doing 3 years from now? What are your goals and how do you plan to achieve them? Be specific.

Skype On-Line Interview

The purpose of the interview is to allow us an opportunity to evaluate your English speaking and listening comprehension skills. The procedure for the interview is as follows:

- Upon receipt of the student's application the Oak Grove International Student Coordinator will review your application and will contact the applicant by e-mail or by telephone to set up a mutually convenient time for the interview.
- The interview will take about 20-30 minutes.
- If you have any questions regarding the procedure of this interview, please e-mail Cindy Vought, international department coordinator, at cindy.vought@oakgrovelutheran.com.

In order to facilitate this process, please provide the following contact information:

Telephone number where you can be reached: _____
Time of day when you can be reached based on Central Standard Time (USA):_____
Your e-mail address: _____
Your Skype screen name: _____
To set up Skype, visit www.skype.com.

Oak Grove Study Abroad Grades and Attendance Record

This form may be reproduced to accommodate multiple years of course studies.

Name of Student: _____

Name of School Currently Attending: _____

School Address: _____

School Telephone: _____ School Fax: _____

Student's Attendance Record:

1. Dates attended: From _____ to _____ (mm/dd/yyyy)
2. Number of Days Required to Attend per year: _____ days
3. Number of Days Absent: Excused: _____ days Unexcused: _____ days

Grades: Please list the number of classes per week and minutes in each period:

The first line serves as an example:

Example: Year 9 out of 12 total years in school system.						
Year _____ out of _____ total years in school system.						
Course of Study in English	**1st Semester**			**2nd Semester**		
	Classes/ week	**Minutes/class**	**Score %**	**Classes/ week**	**Minutes/class**	**Score %**
Example: English	5	50	98%			

* Please indicate using (*) if the student did NOT pass the course.

Signature (Native Language): _____ Date: _____ (mm/dd/yyyy)

Name in Roman Letters: _____

Title: _____

Official School Seal:

General Grading Scale

If your grading scale is different, please indicate corresponding % with appropriate letter grade and provide PROOF of grading scale from your school's headmaster.

Percent %	Letter Grade
90-100	A
80-89	B
70-79	C
60-69	D
0-59	*F

HEADMASTER OR PRINCIPAL RECOMMENDATION

Please enclose reference in envelope and secure with school seal.
Recommendation form must be included with student application.

The following student is a candidate for admission to Oak Grove Lutheran School in the United States. Your careful consideration and evaluation of this student would be greatly appreciated. Please include any observations you believe would be helpful to the admission committee. Thank you for your time and cooperation.

PLEASE RESPOND IN ENGLISH

Name of Applicant _____

1.How long have you known this student? _____

2.Briefly describe the applicant's behavior and attitude.

3.To your knowledge, has the applicant ever been suspended, dismissed or involved in any serious disciplinary action? _____ If yes, please explain.

4.Are you aware of any areas in which this student may need assistance: academic or social? _____
If yes, please explain.

5.Please check one of the following:

_____ I recommend the applicant.

_____ I recommend the applicant with reservation for the following reasons:

_____ I do not recommend the applicant for the following reasons.

Signature _____ Title _____

School _____ Date _____

Address _____ FAX _____

TEACHER / ADVISOR / CLASS MASTER RECOMMENDATION

Please enclose reference in envelope and secure with school seal.
Recommendation form must be included with student application.

The following student is a candidate for admission to Oak Grove Lutheran School in the United States. Your careful consideration and evaluation of this student would be greatly appreciated. Please include any observations you believe would be helpful to the admission committee. Thank you for your time and cooperation.

PLEASE RESPOND IN ENGLISH

Name of Applicant _____

How long have you known this student? _____

Number of years the student has studied English? _____

Please rate the applicant. 1=Unacceptable 2=Below Average 3=Average 4=Good 5=Superior

ACADEMIC ACCOUNTABILITY

Achievement	1 2 3 4 5	Attitude	1 2 3 4 5
Accountability	1 2 3 4 5	Effort	1 2 3 4 5
Motivation	1 2 3 4 5	Conduct	1 2 3 4 5
Responsibility	1 2 3 4 5	Creativity	1 2 3 4 5

ENGLISH LANGUAGE ABILITY

Proficiency	1 2 3 4 5	Reading	1 2 3 4 5
Writing	1 2 3 4 5	Speaking	1 2 3 4 5
Grammar	1 2 3 4 5	Comprehension	1 2 3 4 5

GENERAL CHARACTER

Integrity	1 2 3 4 5	Honesty	1 2 3 4 5
Ambition	1 2 3 4 5	Leadership	1 2 3 4 5
Confidence	1 2 3 4 5	Sociability	1 2 3 4 5
Compassion	1 2 3 4 5	Cooperation	1 2 3 4 5
Maturity	1 2 3 4 5		

COMMENTS

Please share your observations or evaluation of the applicant, in and outside of the classroom. Include comments about the applicant's attendance record, study habits, general attitude, personality strengths and weaknesses. (Please attach separate letter if additional space is needed.)

NAME_____ TITLE_____

SCHOOL_____ DATE_____

To be filled out in English. All information is confidential and will not affect acceptance into program.

OAK GROVE LUTHERAN SCHOOL MEDICAL INFORMATION YEAR_____

Name_____ Grade_____ Sex: M or F
Address (home country)_____
_____
Phone_____

EMERGENCY: Does student have a health problem which could result in an emergency while at school (insect sting, seizure, diabetes, bleeding problems, heart condition, other)? Yes _____ No _____ If yes, please describe:_____
_____

MEDICATIONS taken regularly at home and/or school and reason:
_____
_____
_____

If medication needs to be administered at school, parent must complete school consent form and have it signed by the licensed prescriber. Please contact the Admissions Department to request a form.

VISION: glasses or contacts _____
HEARING:_____
ALLERGIES (i.e., pets, foods, medications, etc.):_____
_____
ASTHMA: need emergency medicatino (Inhaler or EpiPen)?_____
HEART PROBLEMS?_____
SPEECH/LANGUAGE CONCERNS:_____
ATTENTION DEFICIT/HYPERACTIVITY DISORDER? When diagnosed?_____
NUTRITION (special diet, food allergies, diabetes, etc.): _____
EMOTIONAL PROBLEMS (recent death, depression or other):_____
_____
PHYSICAL PROBLEMS OR DISABILITIES:_____
NERVOUS SYSTEM (seizures, weakness, other):_____
CHICKEN POX? Yes _____ No _____ Date of last Tetanus_____
OTHER (skim problems, headaches or other concerns the nurse should be award of): _____
_____
DO YOU SMOKE? Yes _____ No _____ If yes, please be aware Oak Grove will not accept students for enrollment who smoke as it is illegal for anyoneto smoke under the age of 18 in the U.S.

I HEREBY GIVE PERMISSION TO AN AUTHORIZED OAK GROVE SCHOOL OFFICIAL TO OBTAIN MEDICAL ATTENTION FOR MY CHILD IN CASE OF INJURY OR ILLNESS.

Parent/Guardian signature:_____

We authorize Oak Grove school nurse/administration to assist in the dispensing of:
____ Tylenol or cough drops under the instruction of the school nurse and/or administration.
____ I do not want any medication administered to my student.

- In consideration of this authorization made at our request, we do hereby agree to indemnity and save harmless the Board of Regents, the individual members thereof and any officials or employees in charge of dispensing medication from any claims or liability for injury or damages caused or claimed to be caused or to result from the dispensing of "over the counter" medication.

Parent/Guardian signature: _____

Oak Grove Lutheran School Student HEALTH FORM

Name_____ School Year_____

Grade_____ DOB_____ Sex_____

Student's physician/clinic_____ Phone_____

Student's dentist_____ Phone_____

Does student have medical insurance? YES_____ NO_____

HEALTH HISTORY

[**Y**=currently under treatment **N**=no history **R**=problem in the past but currently resolved]

ADD/ADHD	**Y**	**N**	**R**
Asthma	**Y**	**N**	**R**
Bone/Joint Problems	**Y**	**N**	**R**
Diabetes	**Y**	**N**	**R**
Chronic Ear Infections	**Y**	**N**	**R**
Emotional/Behavioral	**Y**	**N**	**R**
Hearing Loss/Issue	**Y**	**N**	**R**
Chronic Headache/Migraine	**Y**	**N**	**R**

Allergies (if yes, see below)	**Y**	**N**	**R**
Heart Condition	**Y**	**N**	**R**
Seizure Disorder	**Y**	**N**	**R**
Head Injury	**Y**	**N**	**R**
Glasses/Contacs	**Y**	**N**	**R**
Weight Concerns	**Y**	**N**	**R**
Nosebleed (freq or severe)	**Y**	**N**	**R**
Skin Problems (chronic or severe)	**Y**	**N**	**R**

Other concerns which may affect student?_____

ALLERGIES Please list and describe any allergies below. Indicate **mild, moderate,** or **severe:**

Bee/Wasp Stings
Medicines/Drugs
Food/Plants/other
Pollen/Dust/Hay Fever
Recommended treatment student currently receives, or has received in the past: *antihistamines:* *inhalers:* *EpiPen:* *other:*

INJURIES & ILLNESSES Please list any severe injuries or illnesses in the student's history.

Injury/Illness	Age of Child	Hospitalized?

Please complete emergency contact information on reverse.

MEDICATIONS

What medications are given daily? Reason?_____

_____

What medications are given frequently, but not daily? Reason?_____

_____

Will your student need to receive medications during the school day?_____

NOTE: If medication is needed at school a **Medication Administration Form** must be signed by you physician and given to the school nurse. This form may be found at the school office, on the Oak Grove website and at most clinics.

I authorize Oak Grove nurse/school to dispense* to my student: **Indicate with Yes or No**

*Dosage given will be determined by student's weight.

Tylenol	
Ibuprofen	
Antacid	

EMERGENCY PHONE NUMBERS and PERSON TO BE CONTACTED WHEN PARENTS/GUARDIAN CANNOT BE REACHED

Mother's Name	Home #	Work #	Cell #
Father's Name	Home #	Work #	Cell #
Other Contact/Relationship	Home #	Work #	Cell #

Please read the following provisions and sign where provided:

→*In consideration of this authorization made by my request, the school and individual dispensing medication, prescription or non-presciption, are not liable for any injury or damages caused by medication.

→*The information on this form is true to the best of by knowledge. I hereby give permission in an emergency situation, when I cannot be contacted, to take my child to the closest medical facility and its medical staff has my authority to provide treatment that a physician deems necessary for the well-being of my child.

→*This form will be utilized for overnight trips, choir tours, mission trips, etc.

→*Information on this form may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signature_____ Date_____

Date & Medication &/or Treatment (school use only)

NORTH DAKOTA
DEPARTMENT of HEALTH

2015-2016 School Immunization Requirements

	Number of Doses Required Per Grade		
Vaccine Type	**Kindergarten**	**Grades 1-6**	**Grades 7-12**
DTaP/DTP/DT/Tdap/Td*	5	5	5
Hepatitis B	3	3	3
IPV/OPV†	4	4	4
MMR	2	2	2
Varicella (Chickenpox)	2§	2§	2§#
Meningococcal¶	0	0	1
Tdap Θ	0	0	1

* One dose of DTaP (pediatric diphtheria, tetanus, and acellular pertussis) vaccine must have been given on or after the 4th birthday. Only four doses are necessary if the 4th dose was administered on or after the 4th birthday. Three doses of Tdap (adolescent/adult tetanus, diphtheria, and acellular pertussis)/Td are required for children ages seven or older who were not previously vaccinated. Tdap should be used as the first dose followed by two doses of Td for children age seven or older not previously vaccinated.

† For polio vaccination, in all-IPV or all-OPV schedule: one dose must have been given on or after the 4th birthday. The final dose in the series should be administered on or after the 4th birthday and at least six months after the previous dose. If four doses are administered prior to age four a 5th dose should be administered at age four through 6 years. Only three doses of IPV are required if the 3rd dose is given on or after the 4th birthday.

§ For the 2015-16 school year, two doses of varicella vaccine are required for kindergarten through seventh grade. If a child has a reliable history of chickenpox disease, the child is exempt from the vaccine requirement.

For the 2015-16 school year, one dose of varicella vaccine is required of children attending eighth through eleventh grade. If a child has a reliable history of chickenpox disease, the child is exempt from the vaccine requirement.

¶ One dose of meningococcal conjugate vaccine (MCV4) is required for entrance into the seventh grade. One dose of MCV4 must have been given on or after the 10th birthday.

Θ One dose of Tdap vaccine is required for entrance into the seventh grade. One dose of Tdap must have been given on or after the 7th birthday.

Exemptions

Students may be exempt from immunization requirements for the following reasons:

- **Medical Exemption:** Requires a certificate signed by a licensed physician stating that the physical condition of the child is such that immunization would endanger the life or health of the child.
- **Philosophical, Moral or Religious Belief Exemption:** Requires a certificate signed by the parent or guardian whose sincerely held philosophical, moral or religious belief is opposed to such immunization.
- **History of Disease Exemption:** Requires a certificate signed by the parent or guardian or physician stating that the child has a reliable history of chickenpox disease.

CERTIFICATE OF IMMUNIZATION

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 16038 (Revised 05-2012)

Division of Disease Control
2635 East Main Ave. PO Box 5520
Bismarck, ND 58506-5520
800.472.2180 or 701.328.3386

North Dakota law requires this form be completed* and provided to the childcare facility or school.

Child's Name (Last, First, Middle Initial):	Date of Birth:
Parent's Name:	Telephone Number:

Vaccine Type		Exemption Check type below€	Enter Month/Day/Year for Each Immunization Given				
Hepatitis B	Hepatitis B	☐					
Rotavirus	Rotavirus	☐					
Hib	*Haemophilus influenzae* type B	☐					
PCV	Pneumococcal conjugate	☐					
DTP/DTaP/DT	Diphtheria-Tetanus-Pertussis	☐					
OPV/IPV	Polio	☐					
MMR	Measles-Mumps-Rubella	☐					
Varicella	Chickenpox	☐			**History of Disease Date:**		
Hepatitis A	Hepatitis A	☐					
Td/Tdap	Tetanus-Diphtheria (and Pertussis)	☐					
MCV4	Meningococcal	☐					
HPV	Human Papillomavirus	☐					
Other		☐					

To the best of my knowledge, this person has received the above-indicated immunizations on the above dates.

Physician, Nurse, Local/State Health	Title	Date

If additional doses are added after initial signature, please initial dose and sign below.

Update signature #1:		
Physician, Nurse, Local/State Health:	Title:	Date:
Update signature #2:		
Physician, Nurse, Local/State Health:	Title:	Date:

My child has not met the minimum requirements for his/her age. I agree to resume immunizations within 30 days from the date I was notified (today's date noted below) that my child's immunizations are incomplete and to submit a signed Certificate of Immunization.

Parent/Guardian Signature: Date:

Statement of Exemption to Immunization Law

In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility.

Medical Exemption: **The physical condition of the above-named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions**.

Physician Signature:	Date:

€***Exemption:*** *(Indicate vaccine above)*

(Please check one) ☐ Religious ☐ Philosophical ☐ Moral ☐ History of Disease

TUBERCULOSIS TESTING

International students may be at higher risk for contracting tuberculosis. To protect international students, as well as the rest of Oak Grove's student body, the following policy has been implemented:

> **International students attending Oak Grove Lutheran School who come from countries at high risk for tuberculosis <u>will be required to have a Mantoux Test prior to participating in classes</u>. Testing is available at local clinics. Please contact Oak Grove's International Coor. upon arrival.**

Negative Mantoux Test:
The result will be documented in the student's school record. No further treatment will be required.

Positive Mantoux Test:
Oak Grove will adhere to North Dakota protocol, which requires the student to have a chest x-ray.

- **Negative Chest X-ray**
  The student will begin a nine month course of INH medication. Follow-up prodecures will be coordinated through the public health system (Cass Public Health). There is no charge for medication.

- **Positive Chest X-ray**
  The student has active tuberculosis. The student's family will be notified immediately to select treatment options. Students with acitve tuberculosis will not be allowed to attend Oak Grove Lutheran School until they are determined to be noninfectious.

All costs associated with receiving this test and any further necessary medical treatment will be billed to the student or student's natural parents or guardian. Failure or refusal to obtain this test and comply with preventative care treatment will result in dismissal of the student and return to home country.

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM - Parent/Athlete fill out prior to physical evaluation

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM - The medical facility should keep this form.

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of MD, DO, PA, NP (print/type) _____ Date _____

Address _____ Phone _____

Signature of MD, DO, PA, NP _____, MD or DO

HE0503 9-2681/0410

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

CLEARANCE FORM - Return this page ONLY to school office

Name _____ Sex ☐ M ☐ F Age _____ Date of Birth _____ Grade _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of MD, DO, PA, NP (print/type) _____ Date _____

Address _____ Phone _____

Signature of MD, DO, PA, NP _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

Wire Instructions for International Wires In

Wire to:

U.S. Bank National Asociation
505 2nd Avenue North
Faro, ND 58102

SWIFT #: USBKUS44IMT

ABA#: 09130023

For Final Credit to: Oak Grove Lutheran School
124 North Terrace
Fargo, ND 58102

Account #: 163070943127

You can also find these same Wire Instructions on the Oak Grove website at:
http://www.oakgrovelutheran.com/en/default/admissions/international-students/