RE-ENROLLMENT FORM

International Student

OAK GROVE LUTHERAN SCHOOL

INTERNATIONAL STUDENT RE-ENROLLMENT FORM

Name of Student: _____

Home City: _____ Country of Citizenship: _____

Sex: Male ____ Female ____ Country of Birth: _____

Re-Enrolling for School Year 20____ - 20____ Grade: □ 9 □ 10 □ 11 □ 12

International Student Office of Admissions

124 North Terrace
Fargo, North Dakota 58102-3899 U.S.A.
Phone: 701.373.7115 • FAX: 701.297.1993
kristi.kegel@oakgrovelutheran.com
www.oakgrovelutheran.com

Date form received by OGLS
_____

To be filled out in English. All information is confidential.

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.

ORTHODONTIC/DENTAL NEEDS/CONCERNS: _____
VISION (glasses, contacts or other): _____
HEARING NEEDS/CONCERNS: _____
ALLERGIES (i.e., pets, foods, medications, etc.):_____

_____

ASTHMA (emergency medication, inhaler or EpiPen): _____
HEART PROBLEMS: _____
SPEECH/LANGUAGE CONCERNS:_____
ATTENTION DEFICIT/HYPERACTIVITY DISORDER: YES/NO If Yes, date of diagnosis:_____
NUTRITION (special diet, food allergies, diabetes, etc.): _____
EMOTIONAL CONCERNS (recent death, depression or other): _____

_____

PHYSICAL CONCERNS OR DISABILITIES:_____
NERVOUS SYSTEM (seizures, weakness, other):_____
CHICKEN POX: YES/NO Date of last Tetanus shot _____
OTHER (skin problems, headaches or other concerns the nurse should be aware 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 anyone under the age of 18 to smoke 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 obtained from the Oak Grove International Coordinator.

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	
Cough Drop	

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)

2019 – 2020 School Immunization Requirements

	Number of Required Doses			
Vaccine Type	**Kindergarten-6**	**Grades 7-10**	**Grade 11**	**Grade 12**
DTaP/DTP/DT/Tdap/Td*	5	5	5	5
Hepatitis B	3	3	3	3
IPV/OPV†¥	4	4	4	4
MMR	2	2	2	2
Varicella (Chickenpox)+	2	2	2	1
Meningococcal¶	0	1	2	2
Tdap ϴ	0	1	1	1

* One dose of DTaP (pediatric diphtheria, tetanus, and acellular pertussis) vaccine must have been given on or after the fourth birthday. Only four doses are necessary if the fourth dose was administered on or after the fourth 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 an all-IPV or all-OPV schedule: one dose must have been given on or after the fourth birthday. The final dose in the series should be administered on or after the fourth birthday and at least six months after the previous dose. If four doses are administered prior to age four, a fifth dose should be administered on or after age four. Only three doses of IPV are required if the third dose is given on or after the fourth birthday. Children born before August 2005 only need four doses separated by at least four weeks. These children do not need a dose after the age of four.

¥ Any doses of OPV administered after April 1, 2016, should not be counted as valid, because it was bivalent or monovalent vaccine, rather than trivalent. The child should be revaccinated with IPV vaccine, accordingly.

\+ For the 2019-2020 school year, two doses of varicella (chickenpox) vaccine are required for kindergarten through eleventh grade. One dose of varicella vaccine is required for twelfth grade.

¶ One dose of meningococcal conjugate vaccine (MCV4) must have been given on or after the tenth birthday. The second dose of MCV4 must be given on or after the sixteenth birthday. If the first dose of MCV4 is given after the sixteenth birthday, then only one dose of MCV4 is required for eleventh and twelfth grade.

ϴ One dose of Tdap must have been given on or after the eleventh 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.
- **Personal Belief 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 a physician stating that the child has a reliable history of disease. History of disease exemptions may only be claimed for hepatitis B, varicella, measles, mumps, or rubella.

Exclusion

All children must be up-to-date according to the school immunization requirements or have claimed an exemption by **October 1st** of each school year or they must be excluded from school. Children enrolling in school after October 1st have 30 days to be up-to-date or claim an exemption or they must be excluded from school.

Updated: 01/14/2019

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

Parent/Guardian Signature	Date

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 _____

_____

_____

PERMISSION FOR MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission for emergency treatment for my daughter/son. I expect an effort will be made to contact me if an emergency occurs. I understand the cost for any medical attention may not be covered or paid by any high school or the North Dakota High School Activities Association. I hereby approve participation in athletic activities.

Grade of Athlete ____ School _____ Sport(s) _____

Parent/Guardian Signature _____ Date _____

DENTAL EXAMINATION FORM

1. STUDENT'S NAME	**2. DATE OF BIRTH** (YYYY/MM/DD)

3. EXAMINATION RESULTS

Dear Doctor,

The individual you are examining is applying for international study in the United States. **Please mark (X) the block** that best describes the condition of the individual, using as a suggested minimum a clinical examination with mirror and probe, and bitewing radiographs.

	(1) Patient has good oral health and is not expected to require dental treatment or reevaluation for 12 months.	
	(2) Patient has some oral conditions, but you do not expect these conditions to result in dental emergencies within 12 months if not treated. (i.e. requires prophylaxis, asymptomatic caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment).	
	(3) Patient has oral conditions that you do expect to result in dental emergencies within 12 months if not treated. Examples of such conditions are: (X the applicable block or specify in the space provided.)	
		(a) **Infections:** Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
		(b) **Caries/Restorations:** Dental caries or fractures with moderate or advanced extension into dentin; defective restorations or temporary restorations that patients cannot maintain for 12 months.
		(c) **Missing Teeth:** Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.
		(d) **Periodontal Conditions:** Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival condition, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances.
		(e) **Oral Surgery:** Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
		(f) **Other:** Temporomandibular disorders or myofascial pain dysfunction requiring active treatment.

(4) If you selected Block (3) above, please indicate the condition(s) you identified in this patient if they appear above, or briefly describe the condition(s) below.

(5) Were X-rays consulted?		**IF YES, DATE X-RAY WAS TAKEN** (YYYY/MM/DD)

4. DENTIST'S NAME (Last, First, Middle Initial)	**5. DENTIST'S TELEPHONE NUMBER** (Include Country Code)
6. DENTIST'S SIGNATURE & LICENSE NUMBER	**7. DATE OF EXAMINATION** (YYYY/MM/DD)
8. ORTHODONTIA (1) Does this student have orthodontic needs?	Students requiring orthodontic care during their time at Oak Grove will work with the International Coordinator to obtain that care.
(2) If yes, briefly describe:	
9. ORTHODONTIST'S NAME (Last, First, Middle Initial)	**10. ORTHODONTIST'S TELEPHONE NUMBER** (Include Country Code)
11. ORTHODONTIC PRACTICE NAME	**12. DATE OF EXAMINATION** (YYYY/MM/DD)

Temporary Guardianship Agreement

I, the undersigned parent of _____ hereafter referred to as
Student's Name

_____, who is a student at Oak Grove Lutheran School in Fargo, North Dakota, do hereby grant
Student's First Name

_____ of _____, the authority to take
Host Parent Name(s) Host Family City of Residence

temporary care of the minor child, _____, the grant of which shall be given on _____
Student's First Name Date of Arrival in U.S.

and continue until terminated by the undersigned or as such time as _____ attains the age of 18,
Student's First Name

whichever may come first.

The above named Temporary Guardian shall have full authority to make routine healthcare decisions for

_____.
Student's First Name

Dated: _____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____

Witnessed by: _____

Statement of Mental Health

International students should have the ability to adapt to a new educational experience, home-life experience, culture and climate with success.

Does your student have any known history of mental or emotional health that impedes his/her ability to navigate and adapt to a new environment and new relationships successfully? ☐ Yes ☐ No

If yes, provide a brief explanation:

I understand that Oak Grove will provide my student a protocol of support should he/she show behavior of concern in the area of emotional and mental health. If the faculty, staff, and host family are unable to meet the needs of my student, I understand that he/she may need to return home.

Parent/Guardian Signature: _____ Dated: _____