INDEPENDENT SCHOOL DISTRICT 595 – East Grand Forks Schools

STUDENT REGISTRATION FORM

STUDENT INFORMATION

Legal Last Name	First Name	Middle Name	Nickname	*(voluntary)* ☐ Special Ed ☐ Active IEP ☐ Gifted/Talented ☐ ESL ☐ 504 ☐ Currently Expelled	**Ethnicity:** *(State of MN Mandate)* **Is this student Hispanic/Latino?** ☐ Yes ☐ No (Cuban, Mexican, Puerto Rican, South/Central American or other Spanish culture or origin, regardless of race)
Birth Date	**Gender** ☐ M ☐ F	**Grade**	**Date moved to #595**		**Student's Race:** *(Choose one or more)* ☐ Amer. Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black, African American ☐ White, not of Hispanic Origin
Student Cell#: **Major Health Concerns:**	**Student lives with:** ☐ **Both Parents** ☐ **Father** ☐ **Mother** ☐ **Guardian** ☐ **Foster Parents** ☐ **Father/Stepmother** ☐ **Mother/Stepfather** ☐ **Other Relationship:**_____				

FAMILY INFORMATION

*** Primary Contact for District Announcements**

*** Primary Parent/Guardian #1:** Last Name	First Name	Relationship	Street Address	City, State, Zip	Cell Guardian #1	Work Phone
*** Primary Parent/Guardian #2:** Last Name	First Name	Relationship	Email Guardian #1	Email Guardian #2	Cell Guardian #2	Work Phone
Request Second Household Mailing: ☐ Yes ☐ No			☐ Homeless, living in a shelter or motel, living with friends or family, temporary foster care, etc.			
Parent/Guardian Second Household Last Name	First Name	Relationship	Street Address	City, State, Zip	Home Phone ☐ Confidential	Work Phone
Parent/Guardian Second Household Last Name	First Name	Relationship	Email (*used most often)*	Cell Guardian (2nd household)	Cell Guardian (2nd household)	Work Phone

Previous School (s) Attended

Name of School	City	State	Dates
Name of School	City	State	Dates

Other Siblings under 21 in home

Last Name	First Name	Gender	Birth date	School attending
Last Name	First Name	Gender	Birth date	School attending
Last Name	First Name	Gender	Birth date	School attending

United States Entry Date: _____

Country of Origin: _____ Parent/Guardian Signature: _____

STUDENT INFORMATION FORM

Student _____ **Date of Birth** _____ **Grade** _____

Contact (Parents/Guardians)
Contact: #1_____Relationship:_____
Phone: _____Work: _____
Contact: #2_____Relationship:_____
Phone: _____Work: _____

Emergency Contact (Family member or friend)
Contact: _____
Relationship: _____
Phone: _____ Work: _____

Storm Home Information for Rural Route Students Only
Contact: _____Phone:_____
EGF Street Address: _____
(Must be within city of EGF)

A. Medical History: (circle the ones that apply to your son/daughter)
Asthma Orthopedic Condition Bleeding Problems Heart Disease Diabetes
Seizure Disorder Fainting Spells Skin Problems Kidney/Bladder Disorder
Depression Anemia Speech Problem Hearing Problems Vision Problems Glasses/Contacts
Allergies Migraines Frequent Stomach Aches
Frequent Ear Aches Eating Disorder Cancer Dental Problems ADD/ADHD/OCD
Learning Disability Frequent Sore Throat Menstrual Problems

If you have circled any of the above, or if any condition exists, please explain and give dates:
_____
_____

B. Allergies: (Circle) Plants Foods Bees/Insects Animals Medications Other
Explain: _____

C. Is medication needed for any condition: At Home: ___ Yes ___ No At School:___ Yes ___ No
(If medication is needed at school the Medication Authorization Form must be completed and returned to school before the medication can be administered) For what condition?
_____

D. Is there a condition that may limit participation in: (circle the ones that apply)
Classroom Activity Physical Education Swimming Competitive Sports
Explain: _____

I agree this confidential information may be shared with faculty and staff of ISD #595 on an as need to know basis so that comprehensive care may be provided to my child. The legal guardian may revoke permission at any time. This expires at the end of the school year.

Parent/Guardian Signature _____ Date _____

Immunization Form

Name_____ Birthdate_____

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months			12 -24 months		At Kindergarten	At 7th grade	At 12th grade
Hepatitis B								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name_____

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature:_____ Date:_____
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I understand that my child may be required to stay home from child care, school, and other activities if exposed.

Signature:_____ Date:_____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me
on _____ (date)
by _____
(name of parent or guardian)

Notary Signature:

_____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF

_____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year_____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature:_____ Date:_____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you chose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature:_____ Date:_____
(of parent/guardian)

HISTORY AND PHYSICAL EXAM FORM

New Heights Elementary
1427 6th Ave NW
East Grand Forks, MN 56721
218-773-0908 / Fax 218-773-3150

PARENT OR GUARDIAN: PLEASE COMPLETE PRIOR TO SEEING PHYSICIAN

Student's Name (Last)_____(First)_____(MI) _____ Sex M__ F __ DOB _____

Parent/Guardian _____Phone (H) _____(W) _____ (C) _____

Grade _____ Age _____ Date _____ School _____

HEALTH HISTORY CONCERNS

Allergies (specify)_____
Asthma _____
Bone/joint (specify)_____
Chicken Pox (month/year) _____
Diabetes_____
Heart Disease_____
Measles _____
Seizures_____
Other _____

DEVELOPMENTAL HISTORY

(enter age below)
Sits Alone_____
Walks Alone_____
Talks Words_____
Talks Sentences_____
Bowel Trained_____
Bladder Trained_____

CURRENT HEALTH

(Specify)

_____ _____
Parent's Signature **Date**

PHYSICIAN: PLEASE COMPLETE THIS SECTION

Indicate Normal (N) or Abnormal (AB) Include comment below:

Height (inch) _____ Ears _____ Orthopedic _____
Weight (lb.) _____ Skin/Lymph _____ Spine _____
Blood Pressure ____/_____ Nose/Throat _____ Neurological _____
Heart Rate _____ Teeth/Mouth _____ Muscular _____
Vision R 20/_____L 20/_____ Heart _____ Speech _____
with glasses Yes__ No__ Lungs _____ Lab Work _____
Hearing R_____ L_____ Abdomen_____ Other _____
Eyes_____ Genitourinary _____ Immunizations given today _____

Ongoing Therapies and Medications:

Problems as Indicated Above - Include Restrictions on Physical Activities - Plans / Recommendations

HEALTH CLASSIFICATION FOR SCHOOL PROGRAM

_____1. Is in excellent health and able to participate in the entire school program.
_____2. There is a condition that may limit participation. (Circle any or all that apply)
Classroom Activities Physical Education Competitive Sports (Give reasons/recommendations above)
Is this a temporary condition YES___ NO_____

Physician's Signature _____Date of examination_____

Physician's Name _____ Address _____Phone _____
(Please Print)

New Heights Elementary
1427 6th Ave NW
East Grand Forks, MN 56721
218-773-0908 / Fax 218-773-3150

Physician's Written Order and Parent Authorization Form

Student: _____ Date of birth _____
Grade: _____ Teacher /Classroom_____

* *

*To be completed by ***PHYSICIAN or AUTHORIZED PRESCRIBER***

Reason for medication: _____
Name of medication: _____
Form of medication / treatment:
___ tablet/capsule ___ liquid ___ inhaler ___ injection ___ nebulizer ___ other

Instructions (schedule and dose to be given at school: _____
_____

Start: _____ date form received Other date: _____
Stop: _____ end of school year Other date: _____
_____ for episodic / emergency events only

Restrictions and / or important side effects: ____ none anticipated _____ yes, describe:_____
_____

Special storage requirements: _____ none _____ refrigerate _____ other

Please indicate if you have provided additional information:
_____ on the back side of this form _____ as an attachment

Date: _____ **Physician name:** _____
Address: _____
Telephone number: _____
Physician's signature: _____

* *

<u>*To be completed by parent / guardian</u>
I give permission for (name of child) _____
to receive the above medication at school according to standard policy.
(Schools require parent / guardian to bring the medication in its <u>original container.</u>)
Date: _____ Signature: _____
Relationship: _____Work Phone: _____Home:_____Cell:_____

Minnesota Language Survey

Minnesota is home to speakers of more than 100 different languages. The ability to speak and understand multiple languages is valued. The information you provide will be used by the school district to see if your student is multilingual. In Minnesota, students who are multilingual may qualify for a Multilingual Seal upon further assessment. Additionally, the information you provide will determine if your student should take an English proficiency test. Based upon the results of the test, your student may be entitled to English language development instruction. **Access to instruction is required by federal and state law. As a parent or guardian, you have the right to decline English Learner instruction at any time.** Every enrolling student must be provided with the Minnesota Language Survey during enrollment. Information requested on this form is important to us to be able to serve your student. Your assistance in completing the Minnesota Language Survey is greatly appreciated.

Student Information	
Student's Full Name: (Last, First, Middle)	Birthdate or Student ID:

	Check the phrase that best describes your student:	**Indicate the language(s) other than English in space provided:**
1. My student first learned:	◯ language(s) other than English. ◯ English and language(s) other than English. ◯ only English.	
2. My student speaks:	◯ language(s) other than English. ◯ English and language(s) other than English. ◯ only English.	
3. My student understands:	◯ language(s) other than English. ◯ English and language(s) other than English. ◯ only English.	
4. My student has consistent interaction in:	◯ language(s) other than English. ◯ English and language(s) other than English. ◯ only English.	

Language use alone does not identify your student as an English learner. If a language other than English is indicated, your student will be screened for English language proficiency.

Parent/ Guardian Information	
Parent/Guardian Name (printed):	
Parent/Guardian Signature:	Date:

* All data on this form is private. It will only be shared with district staff who need the information to best serve your student and for legally required reporting about home language and service eligibility to the Minnesota Department of Education. At the district and at the Minnesota Department of Education, this information will not be shared with other individuals or entities, except if they are authorized by state or federal law to access the information. Compliance with this request for information is voluntary.

DEPARTMENT OF EDUCATION

2019-20 Ethnic and Racial Demographic Designation Form

Student's First Name: _____ Middle Name/Initial: _____ Last Name: _____

Date of Birth: _____ District: _____ School: _____

Schools are required to report ethnicity and race to the state and to the U.S. Department of Education. Because of recent changes to Minnesota state law, Minnesota disaggregates each category into detailed groups to further represent our student populations. Parents or guardians are not required to answer the federal questions **(in bold)** for their children. If you choose not to answer the federal questions **(in bold)**, federal law requires schools to choose for you. This is a last resort—we prefer if parents or guardians complete the form. State questions are labeled as "Optional" and schools will not fill in this information for you.

This information helps improve teaching and learning for everyone and helps us accurately identify and advocate for students currently underserved. The information this form collects is considered private information. You can review the privacy notice to learn more about the purpose of collecting this information, how it will be used and not used, and how the detailed groups were identified. The privacy notice can be found in our *Frequently Asked Questions: Ethnic and Racial Designation Form.*

Is the student Hispanic/Latino as defined by the federal government? The federal definition includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.[1]

[You must select "yes" or "no" to this question.]

○ **Yes** *[If yes, go to Question A.]* ○ **No** *[If no, go to Question 1.]*

Optional Question A: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Guatemalan	☐ Salvadoran	☐ Other Hispanic/Latino
☐ Colombian	☐ Mexican	☐ Spaniard/Spanish/ Spanish-American	☐ Unknown
☐ Ecuadorian	☐ Puerto Rican		

Go to Question 1.

[Select "yes" to at least one of the Questions (1-6) below.]

Question 1: Does the student identify as American Indian or Alaska Native as defined by the state of Minnesota? The state of Minnesota definition includes persons having origins in any of the original peoples of North America who maintain cultural identification through tribal affiliation or community recognition. [This question is needed to calculate state aid/funding.]

○ **Yes** *[If yes, go to Question 1a.]* ○ **No** *[If no, go to Question 2.]*

Optional Question 1a: If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Cherokee	☐ Other North American Indian Tribal Affiliation
☐ Anishinaabe/Ojibwe	☐ Dakota/Lakota	☐ Unknown

Go to Question 2.

[1]Federal Register, Vol. 72, No. 202/Friday, October 19, 2007/Notices/59274

Question 2. Is the student American Indian from South or Central America?

○ **Yes** *[Go to Question 3.]* ○ **No** *[Go to Question 3.]*

Question 3. Is the student Asian as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.[1]

○ **Yes** *[If yes, go to Question 3a.]* ○ **No** *[If no, go to Question 4.]*

Optional Question 3a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Chinese	☐ Karen	☐ Other Asian
☐ Asian Indian	☐ Filipino	☐ Korean	☐ Unknown
☐ Burmese	☐ Hmong	☐ Vietnamese	

Go to Question 4.

Question 4. Is the student black or African American as defined by the federal government? The federal definition includes persons having origins in any of the black racial groups of Africa.[1]

○ **Yes** *[If yes, go to Question 4a.]* ○ **No** *[If no, go to Question 5.]*

Optional Question 4a. If yes was chosen above, select all that apply from the list below (*this question will not be answered by school staff*):

☐ Decline to indicate	☐ Ethiopian-Other	☐ Somali
☐ African-American	☐ Liberian	☐ Other black
☐ Ethiopian-Oromo	☐ Nigerian	☐ Unknown

Go to Question 5.

Question 5. Is the student Native Hawaiian or Other Pacific Islander as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.[1]

○ **Yes** *[Go to Question 6.]* ○ **No** *[Go to Question 6.]*

Question 6. Is the student white as defined by the federal government? The federal definition includes persons having origins in any of the original peoples of Europe, the Middle East, or North Africa.[1]

○ **Yes** ○ **No**

Parent(s)/Guardian Name _____ Date _____

Parent(s)/Guardian Signature _____

SCHOOL BUS REQUEST FORM
2019-2020

This form must be completed and turned into your classroom teacher **before** May 15, 2019

EAST GRAND FORKS PUBLIC SCHOOLS
1420 4TH AVE NW
EAST GRAND FORKS MN 56721
218-773-0476

STUDENT NAME:_____GRADE:_____
(2019-2020)

AM BUSING: Y or N (circle) ***BUS #:*** _____ ***PICKUP TIME:*** _____
To be completed by transportation department

REQUEST BUS TRANSPORTATION IN THE AM FROM: (please print)

_____
(address)
_____

To _____ School.
(school of attendance)

==========

PM BUSING: Y or N (circle) ***BUS #:*** _____
To be completed by transportation department

REQUEST BUS TRANSPORTATION IN THE PM FROM: (please print)

_____ School

To:_____

_
(address)
_____

If going to a daycare after school, please write daycare person and phone number

_____
PARENT/GUARDIAN SIGNATURE/PHONE NUMBER

PLEASE RETURN TO YOUR CLASSROOM TEACHER PRIOR TO MAY 15, 2019

TEACHER: _____

EGF Public Schools

REQUEST FOR RELEASE OF EDUCATION RECORDS

School Last Attended: _____ Phone: _____

Address: _____

_____

Student Name: _____
Last First Middle

Date of Birth: _____ Grade: _____

Student Name: _____
Last First Middle

Date of Birth: _____ Grade: _____

Student Name: _____
Last First Middle

Date of Birth: _____ Grade: _____

Please send:

_____ Health Records
_____ Regular Records
_____ Special Needs Records (i.e. Title, Basic Skills, ESL)
_____ Special Education Records (i.e. Speech, Psychological, SLD, EBD, DCD)

I authorize you to send my child(s) records to:

☐ New Heights Elementary School, 1427 6th Avenue NW, East Grand Forks, Minnesota 56721
Phone: 218-773-0908 Fax: 218-773-3150

☐ South Point Elementary School, 1900 13th Street SE, East Grand Forks, Minnesota 56721
Phone: 218-773-1149 Fax: 218-773-4392

☐ Central Middle School, 1827 Bygland Road SE, East Grand Forks, Minnesota 56721
Phone: 218-773-1141 Fax: 218-773-9112

☐ Senior High School, 1420 4th Avenue NW, East Grand Forks, Minnesota 56721
Phone: 218-773-2405 Fax: 218-773-3070

_____ _____
Signature of Parent/Guardian Date

A school district in which a student enrolls may request student records from a school the student has attended without a parent signature of approval. See "Privacy Act," Section 438, subsection (b) (1), parts A & B, page 97, as amended in 1976, 20 U.S.C. Section 123g(b) (1) (A)

EAST GRAND FORKS ELEMENTARY SCHOOLS

Dear Parents:

An important part of your child's education is that of taking field trips to various places in and around the community of East Grand Forks. We would like to get your permission just one time for the entire year for these local trips.

There are many varieties of trips that are taken by the children. Sometimes we go outside of the city and sometimes we go a few blocks away. Sending a note home with every child each time a trip occurs seems to be a needless waste of your time.

The following are some of the places that children go during the year:

A. Walks around the school area (picnics)
B. Various business establishments in the city
C. Athletic trips around the city (city track meet)
D. University plays, UND library City library
E. Trips outside the city (you will be contacted anytime a trip is planned outside the city

If you feel as though you can give permission one time for all of these events, please indicate on the space provided. If you feel as though you would like to be contacted each time please indicate that on the space provided. When a trip is taken we will simply separate them and contact those who wish to be contacted.

****

(Tear off and return to school as soon as possible)

1. _____ I give permission for my child to attend any activities off the school grounds. (I understand I will be contacted when trips outside the city are planned).
2. _____ I wish for my child's teacher to contact me each time a trip is taken.

Name of Child _____

Parent's Signature_____ Date_____

Parents of East Grand Forks Public School Students

Telephone Consumer Protection Act

Background

The Federal Communications Commission (FCC) created the Telephone Consumer Protection Act (TCPA) in 1991. The rules, among other things, prohibit calls made using automatic telephone dialing equipment or a prerecorded message to any telephone number assigned to a cell phone or any service for which the called party is charged for the call without prior express consent unless the call is for "emergency purposes" which is defined by the TCPA Rules as a call made necessary in any situation affecting the health or safety of consumers. The FCC considers a text message to be a call.

Recent Updates

The FCC met in June 2015 to clarify the TCPA. The ruling approved at this meeting reaffirmed many of the prior provisions of the law and clarified, among other things, the definition of an auto-dialer. The FCC reiterated the need for callers to ensure they have the consent not of the intended recipient of a call, but of the current subscriber, or non-subscriber customary user, of the number being called.

Mass Communication from Schools

While we believe the informational, non-commercial nature of School Messenger messages that ISD 595 will be using for parent notification are compliant with the law. We will be implementing the following processes.

· Obtaining express consent to send messages to each specific contact number via an Affirmative action (also known as opting-in) at the time of collecting contact information
· Never sending commercial messages
· Immediately blocking contact numbers upon recipient request to do so

Parent Name: _____

Oldest ISD 595 student name and Grade: _____

Approved call phone numbers:

_____ _____

_____ _____

_____ _____

Signature: _____

STUDENT INTERNET, COMPUTER AND EQUIPMENT USE AGREEMENT

We have read and agree to comply with the terms of the Independent School District No.595, East Grand Forks, Information Network System -Acceptable Use Policy. We understand that if a student-user violates the terms of that Policy or the directives of a teacher or administrator, he or she may be subject to discipline, up to and including expulsion, as well as civil or criminal penalties that may be imposed by law. Access to the School District's information resources may be revoked at any time.

We understand that modern information technologies offer a wealth of resources for learning, but like any tool, may be misused. We understand that parents/guardians can request alternative activities not requiring Internet access. We agree that the benefits of access outweigh the potential risks and that the responsibility for appropriate use falls on the individual user. We agree to hold the School District harmless for any misuse of its computer systems or any information that may be accessed through the School District's information technology resources.

We understand that in order to administer its information technology resources, the School District can and will monitor use of those resources without notice to users.

Student's Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____

Parent /Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

Teacher's Signature: _____ Date: _____