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 20____ - 20____

Student Photo

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

Program Type Applying for:
- ☐ One Year
- ☐ Diploma Seeking

Associated with/Partnered with (organization): _____

How did you hear about us? _____

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 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 and Student Health Forms
- ☐ Complete Certificate of Immunization Form by Physician
- ☐ Complete Physical Examination and Sports Physical Form by Physician
- ☐ Complete Dental Examination Form by Dentist/Orthodontist
- ☐ Complete Temporary Guardianship Agreement
- ☐ Complete Statement of Mental Health
- ☐ Include application fee of $150 - US Currency (non-refundable)
- ☐ Skype Interview

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) and guardianship letter for medical (TED)
- ☐ Field Trip Form/Participant Travel Waiver
- ☐ Computer Use Form
- ☐ Family Educational Right & Privacy Act Form
- ☐ Wellness Center Waiver and Release Form
- ☐ 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 7-10 days prior to the first week of school.)

STEP 5

- ☐ Proof of Medical Insurance
- ☐ Payment deadline for remaining expenses and 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 Oak Grove's International Coordinator - Kristi Kegel at kristi.kegel@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:
Testing may be required if the Skype interviews are not sufficient. The 2 types of tests and scores Oak Grove Lutheran School uses are: IELTS General Training scores of 5.5 or higher. Toefl preferred score of 35-40 or higher on Internet Based Test (IBT) or 417-433 or higher on Paper Based Test (PBT). School code is B404. Information at www.toefl.org.

_____IMMUNIZATIONS:
The Immunization 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. This process will be completed by Oak Grove's International Coordinator.

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

_____ALL OTHER REQUIRED FORMS:
Must be read and signed by student and natural parent and returned to Oak Grove.

_____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.

Please refer to the Student Handbook for all school rules and regulations.
No reimbursement of tuition, fees, or payments of any kind will be given upon the voluntary withdrawal or dismissal of a student.

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: MM/DD/YYYY

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? Pre-existing conditions such as pregnancy? _____

_____

_____

_____

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 or interested in? _____
   _____

2. Have you taken the TOEFL test? Yes_____ No_____. Have you taken the IELTS 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. How active are you religiously? ☐Very Active ☐Active ☐Inactive

7. What are your goals and your parent's goals for having you attend an American high school such as Oak Grove?
   _____
   _____
   _____
   _____
   _____

8. What languages do you speak or have studied? _____
   _____

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 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, writing, reading 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 45-60 minutes. There may be more than one Skype interview.
- If you have any questions regarding the procedure of this interview, please e-mail Kristi Kegel, International Coordinator, at kristi.kegel@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 Email (Counselor/Principal):_____

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? Yes or No (please circle one) If yes, please explain.

4. Are you aware of any areas in which this student may need assistance: academic or social? Yes or No (please circle one) 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.

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/Contacts	**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 PARENT/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 my 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 | Health
Be Legendary.™

2022-2023 School Immunization Requirements

	Number of Required Doses		
Vaccine Type	**Kindergarten-6**	**Grades 7-10**	**Grade 11-12**
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	1	2
Tdap Θ	0	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 aged 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.

¶ 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.

CERTIFICATE OF IMMUNIZATION

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 16038 (Revised 01-2018)

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

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

Vaccine Type		Exemption Type*	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						
IPV/OPV	Polio						
MMR	Measles-Mumps-Rubella						
Varicella	Chickenpox						
Hepatitis A	Hepatitis A						
Td/Tdap	Tetanus-Diphtheria (and Pertussis)						
MCV4	Meningococcal ACYW-135						
HPV	Human Papillomavirus						
Men B	Meningococcal B						
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) 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 (Med) Exemption:*** *(Indicate vaccine above, requires physician signature)* 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.

☐ ***History of Disease (HD) Exemption:*** *(Indicate vaccine above, requires physician signature)* To the best of my knowledge, the above named person has had prior infection as indicated by prior diagnosis or laboratory confirmation.

Physician Signature:	Date:

Religious (Rel), Philosophical/Moral (PBE) Exemption: *(Indicate vaccine above, requires parental signature)*

Parent/Guardian Signature:	Date:

* **Medical =Med, History of Disease = HD, Religious = Rel, Philosophical/Moral = PBE**

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)

Oak Grove Lutheran Scool

Practice Name: _____
Street: _____
City, ST ZCode: _____

Phone: _____
Fax: _____
Website: _____

Patient			
Name:		DOB:	
Address:		Phone:	

Pediatrician / Family Medicine Physician	
Name:	
Address:	
Phone:	
Fax:	

Other Coordinating Physician	
Name:	
Address:	
Phone:	
Fax:	

This patient received an eye examination on ____ / ____ / ____ **with the following results.**
(Date)

Visual Acuity: Distance	Right	Left	Both
Uncorrected:	20/ ____	20/ ____	20/ ____
Current correction:	20/ ____	20/ ____	20/ ____
Best correction:	20/ ____	20/ ____	20/ ____

Visual Acuity: Near	Right	Left	Both
Uncorrected:	20/ ____	20/ ____	20/ ____
Current correction:	20/ ____	20/ ____	20/ ____
Best correction:	20/ ____	20/ ____	20/ ____

Assessment - Refractive Error	Right	Left	Inconclusive
Emmetropia (No refractive error)	☐	☐	☐
Myopia (Nearsighted)	☐	☐	☐
Hyperopia (Farsighted)	☐	☐	☐
Astigmatism (Differing optical curvatures)	☐	☐	☐

Cycloplegic retinoscopy / refraction	**Dilated Fundus Exam**	**Optomap**
☐ Performed	☐ Performed	☐ Performed
☐ Deferred	☐ Deferred	☐ Deferred
☐ Declined	☐ Declined	☐ Declined

Assessment - Other	Normal	Abnormal*	Inconclusive
Intraocular pressure	☐	☐	☐
Binocular red reflex	☐	☐	☐
Pupillary evaluation	☐	☐	☐
Accommodation (focus ability)	☐	☐	☐
Convergence (eye teaming)	☐	☐	☐
Binocularity / Stereoacuity	☐	☐	☐

	Yes*	No	Inconclusive
Amblyopia (reduced vision w/o organic defect)	☐	☐	☐
Strabismus (eye turn)	☐	☐	☐

Assessment - Other	Normal	Abnormal*	Inconclusive
Color vision	☐	☐	☐
Motility (extraocular muscle function)	☐	☐	☐
Visual field (peripheral vision)	☐	☐	☐
Ocular health (external)	☐	☐	☐
Ocular health (internal)	☐	☐	☐
Other: _____	☐	☐	☐

* Comments: _____

Inconclusive - refers to the inability of the child to perform or complete the evaluation needed to determine assessment.

Treatment	Refractive Error			Additional	
	☐ Rx prescribed	☐ Distance only	☐ Full-time use	☐ Amblyopia therapy prescribed	☐ Medication prescribed
	☐ Rx not prescribed	☐ Near only	☐ As needed use	☐ Specialist referral recommended	☐ Other: See below
Comments:	_____				

Revaluation scheduled in: ____ ☐ Day(s) ☐ Week(s) ☐ Month(s) ☐ Year(s)

Dr. Name: _____ _____ **Date:** ____ / ____ / ____
Print Signature

Vision Source

Note - If faxed, this report must include the HIPAA Privacy Rule fax cover sheet

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 _____

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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

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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 _____

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.

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 must 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 areas 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 will need to return home at the discretion of the school.

Parent/Guardian Signature: _____ Dated: _____

Wire Instructions for International Wires In

Wire to:

BELL BANK
3100 13TH AVENUE SOUTH
FARGO, ND 58103

SWIFT #: BSTTUS44

ABA#: 091310521

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

Further credit/reference: Student's Name

Account #: 6520901890

You can also find these same Wire Instructions on the Oak Grove website at:
https://www.oakgrovelutheran.com/international