

DoDDS - EUROPE  
REGISTRATION QUESTIONNAIRE  
SPONSOR CATEGORY FOR SCHOOL YEAR 2008/2009

This questionnaire is to be used during the registration process to determine the appropriate category of the pupil's sponsor, and to enter the data into the Student Information System (SIS). This form in itself does not grant eligibility. Please check/circle the appropriate category code and attach the documentation required to support enrollment to this form. Failure to provide current eligibility documents will delay enrollment of the listed student(s). All sponsors enrolled in Categories 2, 3, & 4 are required to sign for the DoDEA regulation 1030.1 (Space available eligibility requirements for education of minor dependents in the overseas are, APRIL 04, 2005) and Category 1G, 1H, 2 & 4 is also required to receive the Tuition payment procedure letter.

NAME OF STUDENT(s): \_\_\_\_\_

NAME OF STUDENT(s): \_\_\_\_\_

NAME OF STUDENT(s): \_\_\_\_\_

CODE	DESCRIPTION	DOCUMENTATION REQUIRED (REGISTRAR CONFIRM BY CIRCULING ITEMS PROVIDED)
<b>CATEGORY 1. COMMAND-SPONSORED DoD - (TUITION FREE - SPACE REQUIRED)</b>		
1A	ARMY	B or B + C or D or E
1B	NAVY	B or B + C or D or E
1C	MARINES	B or B + C or D or E
1D	AIR FORCE	B or B + C or D or E
1E	U.S. COAST GUARD	B or B + C or D or E
1F	Full Time DOD US Citizen/National Civilian	B or B + C or D + N or M
1J	Full Time NAFI US Citizen/National Civilian	B or B + C or D + N or M
<b>CATEGORY 1. COMMAND-SPONSORED DoD - (TUITION PAYING - SPACE-REQUIRED)</b>		
1G	MAP + FMS (AGENCY PAYS)	B or B + C or D or E
<b>CATEGORY 1. COMMAND-SPONSORED DoD - (TUITION PAYING - SPACE-CREATED)</b>		
1H	US CONTRACTORS (TUITION PAYING)	A + N or M
<b>CATEGORY 2. FEDERALLY CONNECTED (FC) PERSONNEL - (TUITION PAYING - SPACE AVAILABLE)</b>		
2A	U.S. GOVERNMENT (Example: State DEPT, FAA, GAO, US CIVILIAN NATO, ETC.)	B or B + D or N or M
2B	PART TIME NAFI and Part time Appropriated Funds Employees	D + N or M
2C	U.S. INTEREST (Example: Red Cross, Boy/Girl Scouts, USO Active Duty TDY, NG/Reservist activated less than 180 Days	D or G + N or M (Reservist G + N or M)
2D	FOREIGN SERVICE (Foreign DoD Member serving with NATO, UN, ETC.)	I
<b>CATEGORY 3. NON-COMMAND-SPONSORED DoD - (TUITION FREE - SPACE-AVAILABLE)</b>		
3A	Permanently assigned ARMY & NG/Reservist activated 180 days or more*	B + N or M
3B	Permanently assigned NAVY & NG/Reservist activated 180 days or more*	B + N or M
3C	Permanently assigned MARINES & NG/Reservist activated 180 days or more*	B + N or M
3D	Permanently assigned AIR FORCE & NG/Reservist activated 180 days or more*	B + N or M
3E	Permanently assigned US Coast Guard & NG/Reservist activated 180 days or more*	B + N or M (Reservist G + N or M)
3F	APF sponsors living apart from family overseas	B or D + N or M
3G	SPECIAL CASE (Category 1A-G + 1J sponsors who transfers, dies or retires after the start of the current school year, previously enrolled New USO students, other Secretary of Defense Waivers)	P
3J	NAFI sponsors living apart from family overseas	B or D + N or M
3P	NIS/PFP	I + K
<b>CATEGORY 4. OTHER NON-FEDERALLY CONNECTED - (TUITION PAYING - SPACE AVAILABLE)</b>		
4A	U.S. CITIZEN (PL99-145)	J + O
4B	FOREIGN NATIONAL (PL99-145)	J + O
4C	OTHER U.S. CITIZEN (Retired Military or US Tourist)	J
4D	OTHER FOREIGN NATIONAL (Host Nation Civilians)	J + O

I VERIFY THAT THE CATEGORY CODE AND DOCUMENTATION PROVIDED IS CORRECT

DATE \_\_\_\_\_

SIGNATURE OF SPONSOR or SPOUSE \_\_\_\_\_ (REGISTRAR INITIAL)

## DSE 910- R (Registration Questionnaire documentation information)

### DOCUMENTATION NEEDED TO VERIFY SPONSOR CATEGORY (IAW DoDEA DIRECTIVE 1342.13)

- A. US Government Contractors-Logistical support section of the employees contract Providing DoD Schooling or DOCPER Technical Expert Status Accreditation (TESA) Agreement memorandum or DD1172-2 (Common Access ID Card Application) issued by DOCPER or copy of either the employees Contractor's ID Card or spouses ID card
- B. Sponsor's PCS orders listing family members. US Citizen NATO – Documentation that identifies the Sponsor as a US Citizen serving with other Allied Forces.
- C. Orders for Designated Location Move (DLM) of Dependents listing family members
- D. DSE form 803 Confirmation of Status (MILITARY) validated by the Installation Military Personnel Office or DSE 802 Appropriated/Non Appropriated funds US Civilian Verification form or other employment Documentation from the servicing Human Resource/Civilian Personnel Office Validating employment Overseas. All USO Employees need documentation from the servicing Human Resource/Civilian Personnel Office validating employment overseas.
- E. Approved Command Sponsorship listing student(s) issued by the Installation Military Personnel office or Civilian/Human Resource Office.
- F. Death Certificate and/or Documentation showing sponsor died while entitled to Active Duty Pay or compensation or eligible within a 1-Year period.
- G. CONUS base Active duty US Military/DOD Civilians TDY orders. *National Guard/Reservist orders reflecting Activation.*
- H. Proof of Custody/guardianship or wardship at sponsor's death or birth certificate with the deceased sponsor as one of the biological parents and proof that the surviving spouse of child has a specific relationship to the overseas Country (presence of family, Citizenship or relationship)
- I. Documentation, which identifies the Sponsor as a Foreign DoD Member serving with the Allied Forces.
- J. \*Passport
- K. Approval of the Position as PFP or NIS from the National Military Representative (NMR), or *Allied Joint Force Command HQ Brunssum Memo or US Embassy approval Ankara for NIS billets.*
- L. TAMP ID CARD AND DOCUMENTATION (SEE \* BELOW)
- M. In Loco Parentis (ILP) Documentation: Court Order granting Adoption, Guardianship, Custody or Wardship, ILP Affidavit (DSE801-R) and DoDDS-Europe approval (See \*\* below). Family Care Plan Determinations (CONUS Base single parent, dual military deployments in support of Operation Iraqi/Enduring Freedom) – Memorandum from Unit Commander or first O6 in the chain of command requesting exception to policy for enrollment of deployed family members, deployment order reflecting the number of days deployed (this can also be included in the exception to policy memo), portion of the Family Care Plan reflecting a person who resides in an overseas location as the Family Care Provider (FCP). Power of Attorney granting the FCP the right to act on behalf of the deployed sponsor(s), when an emergency arises at the school. DoDDS-E approval prior to enrollment.
- N. \*\*Birth Certificate reflecting biological connection between the child and sponsor. If the child is biologically connected to the spouse a copy of the marriage and birth certificate is required. If neither are connected no enrollment without DoDDS-E approval. Student ID card - Please ensure that the correct sponsor name is on the student ID Card
- O. Installation pass granting access from the local Installation Commander Office
- P. Category 3G; Special case; Death of sponsor while entitled to Active Duty pay or Civilian compensation or eligible within a 1-Year period (need documentation listed in block "F" and "H" above to support enrollment.

Explanation: of Category 3P: Partnership for Peace (PFP) program currently in DoDDS; SHAPE, Brussels EHS, AFNORTH ES/HS, and Naples ES/HS. The Newly Independent Nations Waiver (NIS) is applicable at Ankara ES/HS.

\* For the applicability of documentation for code "L" (listed above) refer to the relevant category section (either category 1 or 3) in the current Student Eligibility and Enrollment Data Handbook.

\*\* All requests for In Loco Parentis enrollments (Code "M & N" above) must be submitted to the Eligibility POC at DoDDS-E for determination before the student(s) can attend.

**DEPARTMENT OF DEFENSE EDUCATION ACTIVITY  
STUDENT REGISTRATION**

- INSTRUCTIONS**
1. Completed by Sponsor
  2. Print (Ink) or type all entries.
  3. Leave shaded areas blank.
  4. See supplemental sheet for assistance.

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 USC 2164, 20 USC 921

**PRINCIPAL PURPOSE(S):** Required for enrollment of dependents into DoDEA Schools. Provides record of student and sponsor demographic data used in the administration of school programs. Provides emergency contact, pertinent medical and other vital information.

**ROUTINE USE(S):** Data is collected and entered into the automated School Information Management System for use by DoDEA personnel in providing educational and management programs. Release of student information to non-DoDEA personnel is restricted to U.S. Government personnel and other authorized individuals as approved by DoDEA. Sponsor information may be released to other schools, colleges, and prospective employers as part of the individual student record.

**DISCLOSURE:** Voluntary. Disclosure of the Social Security Number will expedite the registration process.

**SECTION I – STUDENT INFORMATION**

1a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone	f. Student SSN / Unique ID	g. Student Grade
h. Birth Date (MMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

2a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone	f. Student SSN / Unique ID	g. Student Grade
h. Birth Date (MMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

3a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone	f. Student SSN / Unique ID	g. Student Grade
h. Birth Date (MMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

**SECTION II – SPONSOR INFORMATION**

4. Sponsor's Name (Last, First, Middle Initial)		5. Sponsor SSN/Unique ID	6. Pay/Civ Grade	7. Title / Rank
8. Organization		9. Location of Unit	10. Duty Phone	11. Rotation / ETS Date
12. Spouse's Name (Last, First, Middle Initial)		13. Spouse's Title	14. Spouse's Employer	15. Spouse's Duty Ph.
16. Mailing Address (e.g. APO/FPO) (If different from Physical)		17. Physical Quarters Address (Street, City, State, Zip Code)		
18. Sponsor Cell Phone	19. Spouse Cell Phone	20. Email Address		
21. Pager Number	22. Reserved	23. Local Use		

**SECTION III – LOCAL EMERGENCY CONTACT INFORMATION**

24a. Emergency Contact Name (Not Sponsor or Spouse)		24b. Contact Duty Phone	24c. Contact Home Phone
24d. Emergency Contact Address (During Day)		24e. Doctor's Name (If not Military Clinic)	24f. Doctor's Phone Number
25a. Emergency Contact 2 Name (Optional)		25b. Contact 2 Duty Phone (Optional)	25c. Contact 2 Home Phone
25d. Emergency Contact 2 Address (Optional)		25e. Local Use	

**SECTION IV – PERMANENT STATESIDE / EMERGENCY CONTACT INFORMATION**

26a. Contact Name	26b. Contact Home Phone
26c. Contact Address	26d. Relationship to Sponsor

**SECTION V – CONSENT and SCHOOL USE INFORMATION**

<p>I understand that I have the right to review my child(ren)'s records and that a copy of the school and health records will be released to the next school (exclusive of colleges and universities) he/she/they attend(s) without further approval.</p> <p>I give permission for my child(ren) to receive first aid at school and any emergency treatment considered necessary with the following exceptions noted below.</p> <p>I verify the information is correct or has been corrected.</p>	34. First Day Student Starts School (MMDDYYYY)	35. DoDAAC
	36. School Name	
	37. Orders on File / Verified <span style="float:right">Y      N</span>	
	38. Birth Date Verified <span style="float:right">Y      N</span>	
27. Exceptions (If none, enter NONE)	39. Reserved <span style="float:right">Y      N</span>	
28. Signature of Sponsor	29. Date (MMDDYYYY)	40. Registrar's Initials
		41. Date (MMDDYYYY)
30. Reserved	31. Reserved	42. Reserved
32. Local Use	33. Local Use	43. Local Use

**Department of Defense Education Activity (DoDEA) Computer and Internet Access Agreement  
Parent Notice of Expectations at Heidelberg High School 2007-2008**

**Privacy Act Statement**

**Authority:** DoD Directive 1342.6, DoD Education Activity, DoDDS System Notice 22  
**Principal Purpose(s):** To permit an individual's use of government-owned computer resources in accordance with DoDEA policies governing use of the Internet and to permit enforcement of DoDEA policies governing access to computers and the Internet.  
**Routine Use(s):** In accordance with DoD published routine uses.  
**Disclosure:** Voluntary; however no individual is permitted to use DoDEA-controlled computer resources until they have signed this statement indicating agreement to use such equipment only in accordance with DoDEA Computer and Internet Access Policies.

**Student Name:** \_\_\_\_\_ **Student Signature:** \_\_\_\_\_

\*\*I, (Parent or Guardian)(Print Clearly) \_\_\_\_\_, have read the Terms and Conditions below. I understand that network access is designed for educational purposes. DoDEA to restrict access to all controversial materials and I will not hold them responsible for materials acquired on the network. Further, I accept full responsibility for supervision if and when my child's use is not in a school setting.  
\*\*I understand, consistent with DoDEA policy to protect individual privacy, my child's written and art work and his or her name may be published, but DoDEA does not authorize the use of photographs, home address, or home telephone number in association with my inconsistent with the Terms and Conditions.  
\*\*I understand: (1) This form does not relinquish my child's rights in his or her work. (2) DoDEA is not responsible for subsequent copying or unauthorized use of the work by an outside person or agency. (3) The only personal identification of the work will be my child's name. (4) My child cannot be directly contacted through the page. All contacts will go through the teacher.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**Terms and Conditions For Students**

- I. **Acceptable Use**
- a. I agree to use DoDEA's computer services only in support of my education and research consistent with the educational objectives of the DoDEA. I will not download files or subscribe to bulletin boards that are not related to my educational activities. If I have questions about my computer use, I will ask my teacher.
  - b. I will respect and adhere to all of the rules governing access to DoDEA computing resources and the rules of any other network or computing resource to which I have access through the DoDEA equipment.
  - c. I understand transmission (sent or received) of any material in violation of any U.S. or state regulation is strictly prohibited and may violate criminal law. I will not transmit obscene, sexually suggestive or offensive, lascivious, harassing, or abusive messages, copyrighted material. Or material protected by trademark or as a trade secret.
  - d. I will not publish the name, photograph, home address or telephone number of myself, another student, faculty, or any other person.
  - e. I understand using the DoDEA computer equipment for commercial, product advertisement or political lobbying is prohibited and may be illegal.
- II. **Privileges**
- a. I understand that the use of the network is a privilege, not a right, and use inconsistent with these Terms and Conditions may result in a cancellation of those privileges. (Each student will receive instruction regarding the terms and protocols referenced in this document before network access is provided.)
  - b. I will be disciplined if I send messaged or download files inconsistent with these Terms and Conditions. At the discretion of the principal and teacher, I may lose the privilege of using the Internet permanently and face suspension or expulsion. Copies of the inappropriate materials will be reported to the building administration and kept on file.
- III. **Internet Etiquette**
- a. I will be polite. I will not use sexual or abusive language in my messages to others.
  - b. I will be courteous, respectful language. I will not swear, use vulgarities, sexual, harsh, or disrespectful language. Illegal activities are strictly forbidden.
  - c. I understand any transmission, including electronic mail, is not private and that my communications and access will be monitored.
  - d. I will evaluate information carefully. As with any research material, I must review it for accuracy and bias.
  - e. I will not use the network in such a way as to disrupt the use of the network by other users. This can be avoided by not sending "chain letters," or "broadcast" messages to lists or individuals.
- IV. **No Warranties**
- a. I understand DoDEA makes no warranties of any kind, whether expressed or implied, for the service it is providing. DoDEA is not responsible for any damages I suffer. This includes loss of data, delays, non-deliveries, misdeliveries, or service interruptions caused by its own negligence or by errors or omissions.
  - b. I understand the use of information obtained via DoDEA is at my own risk. DoDEA specifically denies any responsibility for the accuracy or quality of information obtained through its services. I understand DoDEA has no obligation or authority to defend me against any legal actions brought against me by anyone arising from my misuse of DoDEA computer resources or violations of any U.S. or foreign laws
- V. **Security**
- a. I understand security on any computer system is a high priority, especially when the system involves many users. I will notify my teacher if I notice a security problem. I will not demonstrate the problem to other users.
  - b. I will not give my user password to other individuals. Any activity associated with my account will be considered my activity. It is my responsibility to protect my account and password.
  - c. I may be denied access to the network if I am identified as a security risk.
- VI. **Vandalism**
- a. I understand vandalism will result in cancellation of privileges. I will not maliciously attempt to harm or destroy data of another user, Internet, or any other network. This includes, but is not limited to, the uploading or creation of computer viruses.

# Weapons/Prohibited Substances/Anti-Bullying Policy

**Student Name** (Print Clearly) \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Weapons:** Students shall not transport, exchange, carry on their person, nor cause to be stored, objects that are generally considered to be weapons. These include, but are not limited to firearms, knives, club type weapons (for example, blackjacks, brass knuckles, nunchaku), gas pistols and shooting pens, straight razors, razor blades, Exacto knives, ice picks, clubs, or any object that may be used as a club to inflict bodily harm (for example, pieces of wood or pipe, stones, or bricks). Also banned is any object that might be used readily to inflict bodily harm on self or others (for example, chains, canes with sharp points, broken bottles or glasses, spiked leather, lighters or lazer pointers). Authentic appearing replicas of a firearm are classified as weapons (for example, toy guns). Possession of weapons by students while on school property (to include while riding to or from school or school events on school busses) or in attendance at a school function, or whenever under the jurisdiction of the school, is grounds for expulsion and referral to law enforcement agencies.

**Possession, Sale and/or Use of Alcoholic Beverages, Narcotics, Illegal Drugs and/or Prohibited Substances:** Notices is herby given that all possession, use or sale of controlled (prescription) or mind altering (illegal) substances by any student while the student is on school property (to include while riding to or from school on school buses or at bus stops) or in attendance at a school sponsored function or whenever under the jurisdiction of the school, is grounds for expulsion. Student possession of or being under the influence of alcoholic beverages, and/or hallucinogenic drugs or combinations of drugs or paraphernalia expressly prohibited by federal, or local laws, including prohibited substances which shall include those substances possessed, sold, and/or used that are held out to be, or represented to be, controlled substances, illegal substances, or counterfeit in any respect illegal or controlled substances shall be grounds for expulsion and referral to law enforcement agencies. Prescription medication is not to be transferred to another. Over-the-counter medications are not to be transferred to another or used without parental knowledge. Students should have no more than one dose and the nurse has been informed of the presence of that dose.

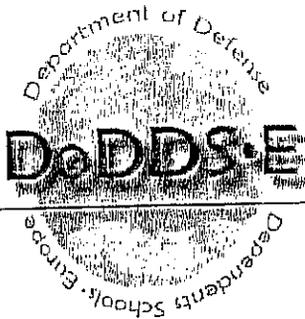
**Sexual Harassment Policy:** Sexual harassment will not be tolerated at HHS. Any student who sexually harasses another student will be counseled and/or disciplined. HHS uses the following definition: sexual harassment is any unwanted and unwelcome sexual behavior, which interferes with a person's education or employment. It can include sexual comments, sexual advances, sexual notes (written or electronic), or sexual contact. Any student who is being sexually harassed should notify a teacher, a counselor or an administrator. Offenders will be counseled once, and then disciplinary action will be taken until the harassment stops.

**Bullying/Harassment/Relational Aggression Policy:** Bullying, Harassment and Relational Aggression will not be tolerated at HHS. Any student who bullies or harasses another student will be counseled and/or disciplined. HHS uses the following definition: a student is being bullied or victimized when he or she is exposed to negative actions on the part of one or more students. Negative actions can be verbal, non-verbal, or physical. Additionally, cyber-aggression, which is bullying via computer means, will not be tolerated. Bullying is aggressive behavior or intentional "harm-doing." It occurs within an interpersonal relationship and is characterized by an imbalance of power. Students are instructed to notify an adult if their efforts to stop bullying are ineffective. School personnel will intervene on behalf of students and parents in an effort to stop the negative actions that are occurring at school.

**I am aware of the zero-tolerance policies listed above.**

**Student Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



*Math Matters!*

**Department of Defense Dependents Schools - Europe  
Office of the Director – Public Affairs  
Publicity Permission Form**

*Within the Department of Defense Dependents Schools - Europe, there are many opportunities to celebrate the achievements and activities of our districts, schools, students, staff and community members. The Information Age has provided additional mediums to publish our accomplishments, showcase our educational programs and services, and strengthen two-way communication among our publics. While television and print publications have been traditional ways of getting information to our publics, we now have the added benefit of the Internet.*

*With regard to the Internet, DoDDS-E official web sites follow the goals, guidelines and policies for responsible and safe Internet publication practices set forth by the Deputy Secretary of Defense and the DoDEA Web Publishing Guide.*

*In order for us to include a student, staff member or community member in print publications, television, multi-media or the Internet, permission is needed.*

**The following is provided for your review and signature:**

I give permission for my child's name, image, and/or student work products to be utilized in various media forms including: newsletters, DoDDS web sites (images only), DoDDS print and video productions, military community publications, military affiliated publications (Stars & Stripes), military affiliated electronic media (AFN/AFRTS), public media (local, host nation, U.S. national newspapers, magazines, television), and future types of media.

Please indicate whether you approve or disapprove by signing below.

\_\_\_\_\_ Approve \_\_\_\_\_  
Printed Name of Child or Individual if for self Signature of child's parent/guardian or individual if for self

\_\_\_\_\_ Disapprove \_\_\_\_\_  
Date Signature of child's parent/guardian or individual if for  
self

SY '07-'08 \_\_\_\_\_ SY '08-'09 \_\_\_\_\_ SY '09-'10 \_\_\_\_\_ SY '10-'11 \_\_\_\_\_

This form is applicable for the current school year and will remain permanently in the student's file. Each subsequent year the student registers, the form is to be reviewed and updated by providing parent/guardian initials next to school year.

Department of Defense Education Activity  
Questionnaire for Race/Ethnicity and Home Language

Completion of this form is required for enrollment in DoD schools. The data collected is maintained for "Statistical Use Only" and is protected in accordance with the Privacy Act (93-579), OMB Circular A-108, and DoD Directive 5400.11. Unauthorized disclosure of this information constitutes a violation of the Privacy Act and may result in a fine up to \$ 5000.

Race/Ethnicity questions comply with OMB Standards for Maintaining, Collecting, and Presenting Data for Race and Ethnicity, dated 30 Oct 97

STUDENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE ANSWER ALL SECTIONS

ETHNICITY (Mark one)

- Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- NOT Hispanic or Latino.

RACE (Mark one or more)

- American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian. A person 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.
- Black or African American. A person having origins in any of the black racial groups of Africa.
- White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

HOME LANGUAGE (Yes or No)

1. Does an adult in the household speak a language other than English at home?  
\_\_\_\_\_ Yes \_\_\_\_\_ No
2. Does the child you are registering speak a language other than English at home?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If the answer to either question number 1 or number 2 is "yes," please complete the Home language Questionnaire.

# DEPARTMENT OF DEFENSE EDUCATION ACTIVITY

## ESL Home Language Questionnaire

**Privacy Act Notice:** Authority to Collect Information: 20 U.S.C. 927(c) and 10 U.S.C. 2164(f), as amended; E.O. 9387; the Privacy Act of 1974, as amended, 5 U.S.C. 552a. **Principal Purpose:** The information will be used within the DoD to determine the services to be provided to a student to assist the child to receive a free appropriate public education. **Disclosure** to the Agency of the information requested on this form is voluntary; but failure to provide all requested information may result in the delay or denial of student services. DoDEA may disclose information requested in this form to other DoD activities and contracted service providers who require the information to deliver educational services to the child and for valid medical, law enforcement or security purposes, or for use in litigation concerning the delivery of student. **Routine Uses:** Disclosure of information contained in this form is authorized outside the DoD in accordance with the "Blanket Routine Uses" described at the beginning of the Office of the Secretary of Defense's compilation of systems of records notices, published at <http://www.defenselink.mil/privacy/notice/osd>.

**THIS FORM IS COMPLETED AT THE TIME OF STUDENT ENROLLMENT**

**Child's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Grade:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

1. What language is commonly spoken in your home?  
\_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
2. Does the child you are registering speak a language other than English? (Excluding foreign languages studied in school.)  
\_\_\_\_ No \_\_\_\_ Yes If yes: What language is spoken? \_\_\_\_\_
3. What language did your child use when he/she first began to talk?  
\_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
4. Has your child attended English speaking schools?  
\_\_\_\_ No \_\_\_\_ Yes If yes: How many years? \_\_\_\_\_
5. What language does your child read and/or write?  
\_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
6. What language do you most often use when speaking with your child?  
\_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
7. What language does your child use most often when speaking to you?  
\_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
8. If your child is cared for by another person on a regular basis, what language is most often used?  
\_\_\_\_ English \_\_\_\_ Another Language (Please specify): \_\_\_\_\_
9. Do you as a parent need to communicate with the school in a language other than English?  
\_\_\_\_ No \_\_\_\_ Yes If yes, in what language? \_\_\_\_\_

Continued on the next page

**ESL Home Language Questionnaire (cont.)**

If based on the results of this questionnaire it is necessary to conduct an evaluation, I understand and give my permission for:

1. My child to be evaluated using a standardized language proficiency test and/or academic achievement test to determine whether he/she is eligible for English as a Second Language (ESL) services. Additional information may be collected from my child's teacher(s) and his/her school records.

**AND**

2. Annual Spring testing to measure my child's academic and English language progress if eligible for services.

I understand that the ESL Teacher will share the results of the assessments with me when testing is completed.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

~~\_\_\_\_\_~~  
To be completed by ESL Teacher:

Recommendation:

\_\_\_\_ Proficiency Testing

\_\_\_\_ Records Review

\_\_\_\_ No ESL Services Required

Signature of ESL Teacher: \_\_\_\_\_

Date: \_\_\_\_\_

~~\_\_\_\_\_~~  
**Distribution: Original to Student's Cumulative File, Copy to ESL Teacher**



MEDICAL POWER OF ATTORNEY

In the event that my dependent (Student's Name) \_\_\_\_\_ is injured or becomes ill, necessitating immediate medical examination or care, while under the supervision or while participating in any activities sponsored by HEIDELBERG AMERICAN HIGH SCHOOL, UNIT 29237, APO AE 09102, I authorize and release to any agent or employee of HEIDELBERG HIGH SCHOOL, Mark Twain Strasse 1, 69126 Heidelberg, Germany, to take my dependent to any U.S. military facility or any civilian hospital if deemed necessary by the above referenced individual.

I understand that the above named personnel of Heidelberg High School will use all diligent and reasonable efforts to contact my spouse or me. If neither my spouse nor I can be contacted after reasonable attempts by personnel of Heidelberg High School or the U.S. treatment facility, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger of life or limb of my dependent. I further authorize non-emergency care necessary treatment such as suturing superficial lacerations, treating colds, minor allergies and minor gastro-intestinal upsets, splinting sprains, casting uncomplicated fractures, or other similar treatments.

MEDICAL INFORMATION ABOUT THE ABOVE NAMED DEPENDENT (to be completed by the parent and shared with school personnel and health care providers on a "need to know" basis)

- > My dependent has the following medical problems (such as diabetes, seizures, asthma, ADHD, heart problems, kidney disease, etc.): \_\_\_\_\_
- > My dependent has had Chicken Pox? Yes (\_\_\_\_\_) OR No (\_\_\_\_\_) mo./yr. Date(s) of Chicken Pox Vaccine(s)
- > My dependent is allergic to the following: \_\_\_\_\_
- > My dependent takes the following medications on a regular and/or "as needed" basis (list name and amount of each medication): \_\_\_\_\_

SPONSOR CONTACT INFORMATION (to be completed at registration and updated as needed by the parent)

Home Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

Sponsor's Name \_\_\_\_\_ Rank \_\_\_\_\_ Cell Phone \_\_\_\_\_

Sponsor's Unit \_\_\_\_\_ Work Phone # \_\_\_\_\_

Spouse's Work Phone # \_\_\_\_\_ (include prefix) Spouse's Cell Phone # \_\_\_\_\_

Other Names and Phone Numbers to Use in Case of Emergency if Parents are Unavailable: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

**I AGREE TO NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES IN THE ABOVE INFORMATION.**

Date \_\_\_\_\_ Signature of Parent \_\_\_\_\_

Sponsor's Social Security Number \_\_\_\_\_

Are you a Civilian "Pay Patient"? \_\_\_\_\_ Yes \_\_\_\_\_ No

**PRIVACY ACT NOTICE:** AUTHORITY: Title V, Sec. 301. PRINCIPAL PURPOSE: To refer to emergency medical facilities in parents' absence. ROUTINE USES: (a) To obtain emergency medical care when parents cannot be reached; (b) To provide emergency contact names; (c) To supply health and medical information about student. Health Data collected will be entered into the school health computer program for use by health and educational personnel on a need to know basis. This form is used by DoDDS employees and trained medical personnel in emergency. Social Security number of sponsor is required by military medical facilities in case of emergency referral. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NON-DISCLOSURE: Mandatory. School personnel will not be able to provide emergency care and health services in parents' absence.

Department of the Army  
U.S. Army MEDDAC, Heidelberg  
CMR 442 APO, AE 09042-0130

I consent for the medical staff of the Adolescent Clinic to see/treat my child or legal ward,  
\_\_\_\_\_ for the following:

- |    | (CHILD'S NAME) | (DATE OF BIRTH) |  |
|----|----------------|-----------------|--|
| 1. | YES            | NO              | Routine school or sports physicals   |
| 2. | YES            | NO              | Minor illnesses, such as stomachaches, earaches, headaches, and colds  |
| 3. | YES            | NO              | Chronic ongoing problems (such as diabetes, asthma, and learning disabilities etc)   |
| 4. | YES            | NO              | Routine laboratory testing   |
| 5. | YES            | NO              | Routine immunizations (such as measles, mumps, polio, flu, tetanus/diphtheria, hepatitis B, and typhoid) and testing for tuberculosis (TB) |
| 6. | YES            | NO              | Counseling for emotional problems  |

If your child is under 15 years of age, please complete items (7) and (8).

- |    |     |    |  |
|----|-----|----|--|
| 7. | YES | NO | Counseling regarding reproductive health and sexual activity, provide contraceptive-related services to include counseling, medication, devices, and treatment of sexually transmitted diseases. |
| 8. | YES | NO | Counseling/treatment regarding alcohol, tobacco and other drugs  |

*Please note that children aged 15 years of age or older are eligible to receive confidential care to include items (7) and (8) if they specifically request it. Provisions of confidential care for children aged 15-17 is described by AR 40-66, section 2-5.*

If my child is seen in the Teen Clinic and I am not present, I understand that the information from those visits may not be routinely discussed with me. However, for non-confidential care I may request information regarding the visits by contacting the Pediatric Clinic, HDB, or by accessing my child's medical record through the Patient Administration Division, Heidelberg MEDDAC.

FOR "PAY PATIENT" SPONSORS (DA CIVILIANS OR DODD CONTRACTORS/EMPLOYEES): I understand that I am responsible for charges for medical services provided for my child. Patients are not charged for confidential care, annual physical exams, or immunizations.  
Charges (if applicable) will be assessed in accordance with AR 40-3.  
PAY PATIENT (circle one): YES NO

(Please Print)

NAME (RANK IF APPLICABLE) \_\_\_\_\_ SPONSOR SSN: \_\_\_\_\_

DEROS: \_\_\_\_\_ RELATIONSHIP TO CHILD: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

SPONSOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

REVIEWED: \_\_\_\_\_ DATE: \_\_\_\_\_

UPDATED MARCH 2005

This consent is in effect for the school year indicated: 2008-2009

\*\*\*PRIVACY ACT STATEMENT ON BACK OF THIS FORM\*\*\*

\*FOR "PAY PATIENT" SPONSORS (DA CIVILIANS OR DOD CONTRACTORS/EMPLOYEES):  
I understand that I am responsible for charges for medical services provided to my child. Charges (If applicable) will be assessed in accordance with AR 40-3.

1. Authority for collection of information including social security number (SSN):

Sections 133, 1071-87, 3012, 5031, and 8012, title 10, United States Code and Executive Order 9397.

2. Principle purposes for which information is intend to be used:

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your child's health care at the Adolescent/Heidelberg Middle School Clinic. The Social Security Number (SSN) of member/sponsor is required to identify and retrieve health care records.

3. Routine uses.

The primary use of this information is to provide, plan, and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical condition required by law to federal, state, and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigation; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of the official duties.

4. Whether disclosure is mandatory or voluntary and effect on individual of not providing information:

The requested information is voluntary. If the requested information is not furnished, non-emergency medical services will not be furnished by Adolescent/Heidelberg Middle School Clinic.

This all-inclusive Privacy Act Statement will apply to all requests for personal information is not furnished, non-emergency medical/dental treatment purposes and will become a permanent part of your child's health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SY 08/09

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY  
STUDENT HEALTH HISTORY

INSTRUCTIONS: SPONSOR/PARENT/GUARDIAN-READ CAREFULLY AND CHECK (✓) ALL CONDITIONS THAT APPLY TO YOUR CHILD.

Student # _____	<b>STUDENT'S NAME (Print) LAST FIRST MI</b>	CHECK <input checked="" type="checkbox"/>	Date of Birth: _____/_____/_____ mo day yr
Grade _____		Female <input type="checkbox"/>	
		Male <input type="checkbox"/>	

**HEALTH HISTORY**

VISUAL DEFECT	✓	COMMENTS	CARDIOVASCULAR	✓	COMMENTS
WEARS GLASSES	<input type="checkbox"/>	For Reading ONLY	SICKLE CELL DISORDER	<input type="checkbox"/>	
CONTACTS	<input type="checkbox"/>		ANEMIA	<input type="checkbox"/>	
COLOR DEFICIENCY	<input type="checkbox"/>		CONGENITAL HEART	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>		RHEUMATOID HEART	<input type="checkbox"/>	
HEARING DEFECT	<input checked="" type="checkbox"/>		HEART MURMUR	<input type="checkbox"/>	
EAR INFECTIONS Frequency:	<input type="checkbox"/>	Last Date:	RESTRICTIONS YES NO	<input type="checkbox"/>	Explain
TUBE IN EAR(S) Left Right	<input type="checkbox"/>	Date of insertion:	OTHER	<input type="checkbox"/>	
HEARING LOSS	<input checked="" type="checkbox"/>		RESPIRATORY	<input checked="" type="checkbox"/>	
MILD Left Right	<input type="checkbox"/>	Date Diagnosis:	ASTHMA Date of Diagnosis:	<input type="checkbox"/>	Inhaler needed: @ school YES NO @ home YES NO
MODERATE Left Right	<input type="checkbox"/>	Date Diagnosis:	BRONCHITIS	<input type="checkbox"/>	
SEVERE Left Right	<input type="checkbox"/>	Date Diagnosis:	CYSTIC FIBROSIS	<input type="checkbox"/>	
HEARING AID(S) Left Right	<input type="checkbox"/>	Date:	TUBERCULOSIS Date of Diagnosis:	<input type="checkbox"/>	Type of Treatment: Date of Treatment:
CONGENITAL EAR DEFECT Left Right	<input type="checkbox"/>		NOSEBLEEDS	<input type="checkbox"/>	Frequency:
ALLERGIES	<input checked="" type="checkbox"/>	ANA Kit Required	SINUSITIS	<input type="checkbox"/>	Frequency:
BEE STING	<input type="checkbox"/>	YES NO	DERMATOLOGY	<input checked="" type="checkbox"/>	
FOOD (SPECIFY)	<input type="checkbox"/>	YES NO	PROBLEMS WITH BODY PIERCING/TATOOS	<input type="checkbox"/>	
DRUG (SPECIFY)	<input type="checkbox"/>	YES NO	FEVER BLISTERS COLD SORES	<input type="checkbox"/>	
ENVIRONMENTAL	<input type="checkbox"/>		CONTACT DERMITITIS	<input type="checkbox"/>	
SEASONAL	<input type="checkbox"/>		ACNE	<input type="checkbox"/>	
LACTOSE INTOLERANCE	<input type="checkbox"/>		ECZEMA	<input type="checkbox"/>	
ENDOCRINE	<input checked="" type="checkbox"/>		DANDRUFF	<input type="checkbox"/>	
DIABETES Date Diagnosed:	<input type="checkbox"/>	Insulin needed: @ school YES NO @ home YES NO	TINEA (RINGWORM) Body Head Feet	<input type="checkbox"/>	
HYPERGLYCEMIC	<input type="checkbox"/>		MUSCULO/SKELETAL	<input checked="" type="checkbox"/>	
HYPOGLYCEMIC	<input type="checkbox"/>		ARTHRITIS	<input type="checkbox"/>	
THYROID DISORDER	<input type="checkbox"/>		MUSCULAR DYSTROPHY	<input type="checkbox"/>	
PARISITES (HISTORY OF)	<input checked="" type="checkbox"/>		HISTORY OF FRACTURE Explain:	<input type="checkbox"/>	Date:
MALERIA	<input type="checkbox"/>		SCOLIOSIS	<input type="checkbox"/>	Date Diagnosed:
PIN WORMS	<input type="checkbox"/>		DEFORMITY Explain:	<input type="checkbox"/>	
SCABIES	<input type="checkbox"/>		HERNIA	<input type="checkbox"/>	
HEAD LICE	<input type="checkbox"/>		OSGOOD-SCHLATTER	<input type="checkbox"/>	

**CONTINUE ON REVERSE SIDE**

## STUDENT HEALTH HISTORY – CONTINUED

NEUROLOGY	✓	COMMENTS	GASTROINTESTINAL/ GENITOURINARY	✓	COMMENTS
CEREBRAL PALSY	<input type="checkbox"/>		BLADDER CONTROL PROBLEMS Explain:	<input type="checkbox"/>	
SEIZURE DISORDER	<input type="checkbox"/>	Date of last seizure: Medication needed: @ school YES NO @ home YES NO	URINARY TRACT INFECTION Explain Frequency:		Date of last infection:
MIGRAINE Specify Frequency	<input type="checkbox"/>	Date of last migraine: Medication needed: @school YES NO @ home. YES NO	BOWEL CONTROL PROBLEMS Explain:	<input type="checkbox"/>	
SPINA BIFIDA	<input type="checkbox"/>		<b>DENTAL</b>	✓	
SLEEP DISORDER	<input type="checkbox"/>		BRACES	<input type="checkbox"/>	
HEADACHES Specify Frequency	<input type="checkbox"/>		CAVITIES: Date of last Dental Exam:		
PSYCHIATRIC	✓		CANKER SORES		
ATTENTION DEFICIT (HYPERACTIVITY) DISORDER ADD/ADHD	<input type="checkbox"/>	Date of Diagnosis: Medication needed: @ school. YES NO @ home YES NO	NUTRITION METABOLIC	✓	
DEPRESSION Date Diagnosed:	<input type="checkbox"/>	Medication needed: @ school YES NO @ home. YES NO	NUTRITIONAL PROBLEMS Explain:	<input type="checkbox"/>	
AUTISM	<input type="checkbox"/>		OVERWEIGHT/OBESE	<input type="checkbox"/>	
SUICIDAL History of	<input type="checkbox"/>	Date:	POOR APPEITITE	<input type="checkbox"/>	
SUBSTANCE ABUSE, History of	<input type="checkbox"/>	Circle: Drugs, Alcohol, Tobacco, and/or Inhalants Date:	MISCELLANIOUS	✓	
ANOREXIA	<input type="checkbox"/>		THUMBSUCKING	<input type="checkbox"/>	
BULIMIA	<input type="checkbox"/>		MOTION SICKNESS	<input type="checkbox"/>	

### MEDICATION AND HOSPITALIZATION

<b>DOES YOUR CHILD NEED TO TAKE DAILY MEDICATIONS AT SCHOOL?</b> A medication during school hours form <b>MUST</b> be signed by a physician and a parent and <b>MUST</b> accompany prescribed medications. All medications taken at school <b>MUST</b> be maintained and administered from the health office under school personnel supervision. <b>SPECIFY ALL CURRENT MEDICATIONS (to include medications taken at home):</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Comments
<b>HAS YOUR CHILD BEEN HOSPITALIZED?</b> Specify the date and reason: Date: _____ Length of Hospitalization _____ SPECIFY REASON: mo/day/yr.	YES <input type="checkbox"/> NO <input type="checkbox"/>	Comments

### SPACE BELOW FOR PARENT TO PROVIDE ADDITIONAL INFORMATION CONCERNING OTHER MEDICAL CONDITIONS.

(PLEASE PRINT)

\_\_\_\_\_ My child had the chicken pox vaccine

\_\_\_\_\_ My child had the chicken pox \_\_\_\_ / \_\_\_\_ month/year

\_\_\_\_\_ I understand that my child's immunizations must be updated and turn-in before school registration is complete. If immunizations are due during the summer months, I will bring the updated immunization record to the school prior to the first day of school.

#### PRIVACY ACT NOTICE

**AUTHORITY:** Sections 113, 136 and 2164 of title 10, and 921-932 of title 20 of the United States Code.  
**PRINCIPAL PURPOSE:** To promote student's health for learning.  
**ROUTINE USE (S):** Disclosures are authorized by 5 U.S.C. 552a(b) of the Privacy Act within DoD and outside DoD as a routine use pursuant to DoD Blanket Routine Uses set forth at <http://defenselink.mil/privacy/noticesosd>, authorized by 5 U.S.C. 552a(b)(3).  
**DISCLOSURE:** Voluntary. Without this information school personnel will not be able to provide appropriate education and health services.

Parent/Sponsor's Signature:	Date:
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\*To be completed by the nurse at registration\*

The understand that the following immunizations are due prior to the first day of school