APPLICATION FOR ADMISSION

International Student

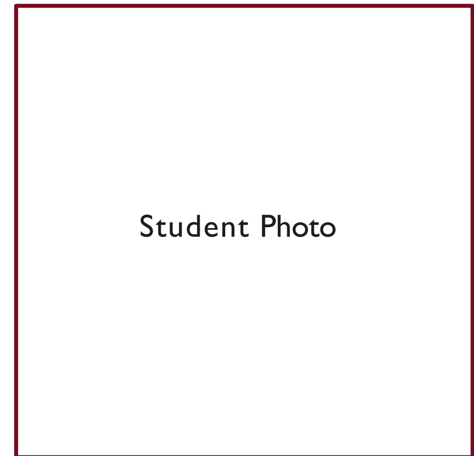
INTERNATIONAL STUDENT APPLICATION FOR ADMISSION

Name of Applicant: ____

Home City: ______________________ Country of Citizenship: ____________________

Sex: Male ____ Female ____ Country of Birth: ______________________

Applying for School Year 20____ - 20



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 $250 - 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 $250 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. Please also provide non-translated transcripts in home language.**

______**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. **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 video 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:

- How do you handle a conflict with your peers? Give an example of a time you needed to manage a conflict with your peers and the outcome.

- 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 10 years from now? What are your goals and how do you plan to achieve them?Be specific.

Online Video 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 video 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 preferred platform for video calling: : ______________________________

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 ____ Email _______________________

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 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]

Condition	
ADD/ADHD	
Asthma	
Bone/Joint Problems	
Diabetes	
Chronic Ear Infections	
Emotional/Behavioral	
Hearing Loss/Issue	
Chronic Headache/Migraine	

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

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?

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

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

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)

Is your student ready for school?

Immunization Requirements

Use this chart as a guide to determine which vaccines are required to enroll your student in school (public, private, or homeschool). Check marks show the number of required doses.

This schedule shows the ages when doses are due.

Kindergarten - 6th Grade	7th - 10th Grade	11th - 12th Grade
Hepatitis B ✓✓✓	Hepatitis B ✓✓✓	Hepatitis B ✓✓✓
DTaP ✓✓✓✓✓	DTaP ✓✓✓✓✓	DTaP ✓✓✓✓✓
Polio ✓✓✓✓	Polio ✓✓✓✓	Polio ✓✓✓✓
MMR ✓✓	MMR ✓✓	MMR ✓✓
Chickenpox ✓✓	Chickenpox ✓✓	Chickenpox ✓✓
	Meningococcal ✓	Meningococcal ✓✓
	TDaP ✓	TDaP ✓

Exemptions

To enroll in school in North Dakota, children must show they've had these immunizations or file a exemption with the school.

Parents may file a medical exemption signed by a health care provider or a non-medical exemption signed by a parent/guardian. A blank exemption form can be found on our website.

NORTH Dakota Be Legendary. | Health & Human Services

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,

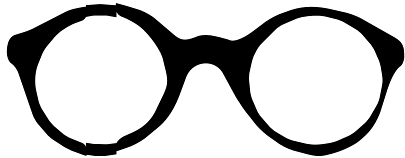
The individual you are examining is applying for international study in the United States. **Please mark (X) the block** that best describes the condition of the individual, using as a suggested minimum a clinical examination with mirror and probe, and bitewing radiographs.

	(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	**Other Coordinating Physician**
Name	Name
Address:	Address
Phone	Phone
Fax:	Fax:

This patient received an eye examination on _____ / _____ / _____ **with the following results.**

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

☐ Rx prescribed ☐ Distance only ☐ Full-time use
☐ Rx not prescribed ☐ Near only ☐ As needed use

Additional

☐ Amblyopia therapy prescribed ☐ Medication prescribed
☐ Specialist referral recommended ☐ Other. See below

Comments ____

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

Dr. Name: **Date:** ____ / ____ / ____

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■ NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: ______________________________ Date of birth: ______________

Date of examination: ______________ Sport(s) ______________________________

Sex __________ Age __________ Grade ________ School ______________________________

List past and current medical conditions. ______________________________

Have you ever had surgery? If yes, list all past surgical procedures. ______________________________

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). __

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). ______________

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic poly- morphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

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NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had, or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

____

____

____

____

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____

____

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

Signature of athlete: ____

Signature of parent or guardian: ____

Date: ____

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■ **NDHSAA PREPARTICIPATION PHYSICAL EVALUATION**

PHYSICAL EXAMINATION 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, e-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-enhancing 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 (Q4–Q13 of History

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: □ Y □ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type):______________________________Date: ____________

Address:____Phone: ______________

Signature of health care professional:______________________________________, MD, DO, NP, or PA

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■ NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: ______________________________________ Date of birth: ______________________________

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

____

____

☐ Medically eligible for certain sports

____

____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: ____

____

____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type):___________________________________Date: _______________

Address:____Phone: ____________________

Signature of health care professional:____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: ____

____

Medications: ____

____

Other Information: ____

____

Emergency Contacts: ____

____

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 ___________________________

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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