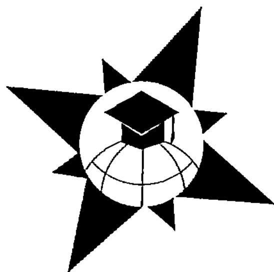
APPLICATION
2020-21 School Year



Career Pathways Public Charter Secondary School
Phone: 651-400-1781
Fax: 651-400-1782

Student Name: ____ ****Entering Grade:** _____

Please print neatly

Parent/Guardian Name (s): ____

Address: ____ Apt. # __________

City: ____ State: ______ Zip: ____________

Home/Main Phone: ____

Email Address: ____

Student Date of Birth: __________________

Sibling Name/Grade: ____

Due to sibling enrollment preference required by Minnesota Law, Career Pathways asks that you identify siblings who are concurrently applying for admission at Career Pathways. All siblings must have a separate form.

Parent Signature: ____

By signing this form I give permission for student records to be requested from the previous school for enrollment.

I understand that providing false or inaccurate information will void this application and the spot will be given to the next child on the waitlist.

If we receive more applications than there are spaces; students are placed on a waiting list and/or may be a part of a lottery.

____

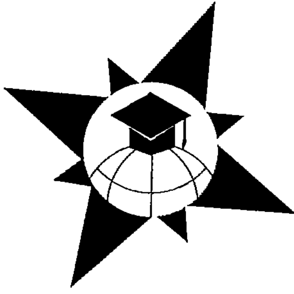
Director's Signature ***Date***

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

For Office Use	Enrolled? Y/N Grade: _____
Included in Lottery? Y/N	Date Received: ______________

Please send applications to: Career Pathways, 1355 Pierce Butler Rt., St. Paul, MN 55104

OFFICE DRIVE



Student Name:

Grade:

Outings/Field Trips/Transportation Release

I understand that an important and regular part of the school program includes outings into the community and frequent field trips and field experiences. I understand that these trips may utilize public transportation accompanied by volunteer parents and/or school staff. I also understand that students will engage in walking trips in and around the community accompanied by volunteer parents and/or school staff. I give my permission for my child to participate in these trips.

I acknowledge that participation in Field Trips involves some risk of physical injury. I have been informed of and agree to expressly accept and assume any and all risk of injury or sickness arising from such participation. I recognize that Career Pathways does not carry health or accident insurance or other insurance for medical hospitalization expenses arising from such injuries or sickness. In consideration of participating in Field Trips, we hereby agree to waive, release, and forever discharge Career Pathways , its officers, directors, sponsors and employees from any and all liability from the participation in this activity.

Parent Signature Date

OFFICE DRIVE

Minnesota Department of

Education

Home Language Questionnaire

ED-01336-08E

The following is to be completed by School District Personnel:

STUDENT IDENTIFICATION INFORMATION		
Student's Full Name		
Date Of Birth	Age	Grade Level

DISTRICT INFORMATION/VERIFICATION INFORMATION	
School name Career Pathways	District number 4237

I hereby verify that the above information is true and accurate to the best of my knowledge and belief.

Name (Printed)

Signature – Responsible Authority   Title   Date

The following is to be completed by Parent/Guardian:

STUDENT LANGUAGE INFORMATION

Dear Parents and Guardians:
In order to help your child learn, your child's teachers need to determine which language your child uses most. Please respond to the questions below by checking the appropriate box.

1. Which language did your child learn first? ☐ English ☐ Other (specify): ____________
2. Which language is most often spoken in your home? ☐ English ☐ Other (specify): ____________
3. Which language does your child usually speak? ☐ English ☐ Other (specify): ____________

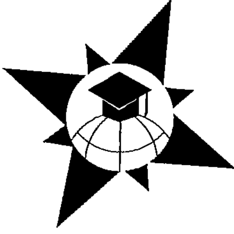
PARENT/GUARDIAN INFORMATION

I hereby verify that the above information is true and correct to the best of my knowledge and belief.

Name (Printed)

Signature – Parent/Guardian   Date

Intake Interview



1. Student Information

Last Name: ______________________ First Name: ______________________

Expected grade level at time of enrollment: __________

Identifies with: ❑ Male ❑ Female

2. Immigration Status

Birth Country: ________________________

Immigrant From: ______________________

Immigration Date: _____________________

3. Homeless Status

Does student have a permanent place to stay? Yes or No

If no, where does student most often stay? ______________________________

4. Services received at previous school? (☑ Mark all that apply.)

❑ Special Education

❑ English as second language support

❑ Other: ___________________________

5. Schools Attended (most recent first; use reverse as needed):

Name of School	Grade(s)	Dates

6. Is the student interested in bus transportation? Yes or No (circle one)

Completed By:
Date:

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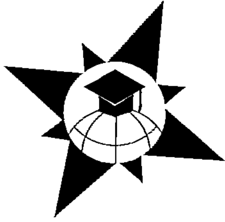

Student Health Profile

Student Name: Grade:

Emergency Contact

Name		**Relationship**	
Primary Phone		**Other Phone**	

Name		**Relationship**	
Primary Phone		**Other Phone**	

Physician/Doctor		**Phone**	

Health Conditions

Condition	**Start Date**	**Comment**
Allergies		
Recent surgery, accident, or illness?		

Does the student take daily medication? ☐ Yes ☐ No

If yes, please specify:

I, the undersigned parent/guardian, give my consent for the above named child to be released to me or my spouse or to the emergency contact I have designated above, and/or to be taken by ambulance to the nearest hospital in case of emergency.

I understand that Career Pathways does not provide accident medical/dental coverage for students for injuries/illnesses occurring at school. I further acknowledge **that I am financially responsible for medical, dental, ambulance, or other health care expenses** or transportation of my child home, which might occur as a result of such illness or injury.

Parent Signature Date

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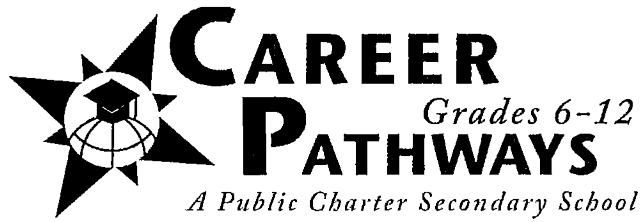

Administration of School Supplied Acetaminophen (Tylenol) and Antacid for Middle School and High School Students

Purpose: Over the counter (OTC) pain relief medications can be obtained without a doctor's prescription and are used for the relief of pain symptoms on a temporary basis. Appropriate use of over the counter pain relief medications at school can assist students to remain in school and continue to achieve in the classroom. The American Academy of Pediatrics Policy Statement for Administration of Medication in School states "providing parent approved short-term medications, such as pain relievers, may provide symptomatic improvement for the student, which enables attendance for learning and causes less classroom disruption."

Valid for current school year 20-21

Student name: ____________________________ **Date of birth:**________ **Grade:**________

I give permission to authorized school staff to give my child acetaminophen (Tylenol) and Antacids when determined to be needed for stomach ache, nausea, headache, menstrual cramps or tooth/orthodontic pain. The student will be able to receive 5 doses throughout the school year. When 5 doses have been given the parent will be notified.

Select a medication and dose to be given

Acetaminophen (Tylenol) 500mg tablets- give 1 or 2 (circle) tablets

Anti Acid - give 1 or 2 (circle) tablets

Does this student have any drug allergies? List ________________________________

Does this student have any chronic health conditions? List ______________________

Date	Time	Medication	Dosage	Reason or need for Medication	Initials

Parent/guardian signature____ Date___________

School health secretary signature______________________________________ Date___________

OFFICE DRIVE

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

Immunization Form

Name______________________ Birthdate__________

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

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

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

Instructions for parent or guardian:

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

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

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

Name ________________________________

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

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

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

Signature: ______________________________ Date: __________
(of health care practitioner*)

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

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

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

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

This document was acknowledged before me

on ______________ (date)

by ______________________________
(name of parent or guardian)

Notary Signature:

____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF

____

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

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

- ☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.
- ☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

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

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

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

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

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

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

Signature: ______________________________ Date: __________
(of parent/guardian)

DEPARTMENT OF EDUCATION

2020-21 Application for Educational Benefits

Complete one application per household for all children. Please use pen (not a pencil). **Mail or return completed form to: (*School/District Information*)** ______________________________

STEP 1: List ALL Household Members who are infants, children, and students up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper).

Definition: A Household Member is "Anyone living with you and shares income and expenses, even if not related." Children in Foster care are eligible for free meals. Read *How to Complete the Application for Educational Benefits* for more information. Adults over grade 12 living in the same household should be reported in Step 3. If your children attend different districts or charter/nonpublic schools, return an application at each one.

Child's First Name (list all children in household)	MI	Child's Last Name	School	Grade	Birthdate	Foster Child (√)
						☐
						☐
						☐
						☐
						☐

STEP 2: Do Any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, MFIP or FDPIR? Medical assistance **does not** qualify. **If NO** > Go to STEP 3.
If YES >Enter SNAP, MFIP or FDPIR Case Number (between 4-9 digits, do not report EBT card number) ___ ___ ___ ___ ___ ___ ___ ___ ___ then go to STEP 4 (Do not complete STEP 3)

STEP 3: Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

A. **Last Four Digits of Social Security Number (SSN)** of Adult Household Member: **XXX-XX-** ☐ ☐ ☐ ☐ Or Check if Adult has **No SSN:** ☐ **Total Number of All Household Members** (Children + Adults) ☐

B. **Child Income.**
Sometimes children in the household earn or receive income, such as from a part time job or SSI. Please include the TOTAL income received by all children listed in STEP 1. Do not include income received by adults in the box to the right.

Total Income Received by All Children	Weekly	Bi-weekly	2x Month	Monthly
$	☐	☐	☐	☐

C. **All Adult Household Members (including yourself).** For each Household Member listed, if they do receive income, report total gross income only. If they do not receive income from any source, write '0' or leave any fields blank. You are certifying (promising) that there is no income to report. Not sure what income to include here? Flip the page and review "Sources of Income" for information. "Sources of Income" will help you with the Child Income section and All Adult Household Members section.

Names of All Adult Household Members (First and Last)	Gross Earnings from Working at Jobs					Are you Self-Employed or a Farmer?			Any Other Gross Income				
List all Household members not listed in STEP 1 (including yourself) even if they do not receive income. Include children who are temporarily away at school or in college.	Weekly	Bi-weekly	2x Month	Monthly	Report income **before deductions or taxes** in whole dollars (no cents).	Monthly	Yearly	**Net income** from Farm or Self-Employment. Do not duplicate elsewhere.	Weekly	Bi-weekly	2x Month	Monthly	SSI, Unemployment, Public Assistance, Child Support, and others on Page 2
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$
	☐	☐	☐	☐	$	☐	☐	$	☐	☐	☐	☐	$

STEP 4: Contact information and adult signature. "I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is give in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

☐ I have checked this box if I *do not* want my information shared with Minnesota Health Care Program as allowed by state law.

Printed name of adult signing form — Daytime Phone

Street Address (if available) — Apt# — City — Zip

SIGN HERE: Signature of Household Adult — Date

Do Not Fill Out: For School Office Use Conversions to Annualize All Income:	X52	X26	X24	X12	X1	☐ **Verified? Attach Tracker**	No change ☐	Free After Verified ☐	Reduced After Verified ☐	Denied After Verified ☐
All Total Income (Include child and adult income)	Weekly	Bi-weekly	2X Month	Monthly	Annualize	**Household Size:**	Categorical Eligibility	Free	Reduced	Denied
$	☐	☐	☐	☐	☐		☐	☐	☐	☐
Determining Official Signature:							**Date:**			
Confirming Official Signature:							**Date:**			

See Page 2 for Additional Information. Return completed form to the school at the address listed at the top of the form. Do not mail to the Minnesota Department of Education or United States Department of Agriculture.