

**SECTION 16**

**Permission/Objection Sheets**

**OBJECTION TO PUBLICATION OF DIRECTORY INFORMATION**

**School Board Policy 4.13F---Objection to Publication of Directory Information**

(Not to be filed if the parent/student has no objection)

I, the undersigned, being a parent of a student, or a student eighteen (18) years of age or older, hereby note my objection to the disclosure or publication by the Nemo Vista School District of directory information, as defined in School Board Policy No. 4.13 (Privacy of Students' Records), concerning the student named below. The district is required to continue to honor the signed opt-out form for any student no longer in attendance at the district.

I understand that the participation by the below-named student in any interscholastic activity, including athletics and school clubs, may make the publication of some directory information unavoidable, and the publication of such information in other forms, such as telephone directories, church directories, etc., is not within the control of the District.

I understand that this form must be filed with the office of the appropriate building Principal within ten (10) school days from the beginning of the current school year for the District to be bound by this objection. Failure to file this form within that time is a specific grant of permission to publish such information.

My objection is to the disclosure or publication of directory information to

Military recruiter's \_\_\_\_\_

Public and school sources \_\_\_\_\_

Both military recruiters and public and school sources \_\_\_\_\_

\_\_\_\_\_

Name of student (Printed)

\_\_\_\_\_

Signature of parent (or student, if 18 or older)

\_\_\_\_\_

Date form was filed (To be filled in by office personnel)

#### 4.35- MEDICATION SELF-ADMINISTRATION CONSENT FORM

Student's Name (Please Print): \_\_\_\_\_

This form is good for the school year 2024-2025. This consent form must be updated anytime the student's medication order changes and renewed each year and/or anytime a student changes schools.

The following must be provided for the student to be eligible to self-administer rescue inhalers and/or auto-injectable epinephrine. Eligibility is **only** valid for this school for the current academic year.

- A written statement from a licensed health-care provider who has prescriptive privileges that he/she has prescribed the rescue inhaler and/or auto-injectable epinephrine for the student and that the student needs to carry the medication on his/her person due to a medical condition;
- The specific medication prescribed for the student;
- An individualized health care plan developed by the prescribing health-care provider containing the treatment plan for managing asthma and/to anaphylaxis episodes of the student and for medication use by the student during school hours; and
- A statement from the prescribing health-care provider that the student possesses the skill and responsibility necessary to use and administer the asthma inhaler and/or auto-injectable epinephrine.

If the school nurse is available, the student shall demonstrate his/her skill level in using the rescue inhalers and/or auto-injectable epinephrine to the nurse.

Rescue inhalers and/or auto-injectable epinephrine for a student's self-administration shall be supplied by the student's parent or guardian and be in the original container properly labeled with the student's name, the ordering provider's name, the name of the medication, the dosage, frequency, and instructions for the administration of the medication (including times). Additional information accompanying the medication shall state the purpose for the medication, its possible side effects, and any other pertinent instructions (such as special storage requirements) or warnings.

Students who self-carry a rescue inhaler or an epinephrine auto-injector shall also provide the school nurse with a rescue inhaler or an epinephrine auto-injector to be used in emergencies.

I understand this form authorizes my student to possess and use the medication(s) included on this form while on school grounds and at school-sponsored events but that distribution of the medication(s) included on this form to other students may lead to disciplinary action against my student.

My signature below is an acknowledgment that I understand that the District, its Board of Directors, and its employees shall be immune from civil liability for injury resulting from the self-administration of medications by the student named above.

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

**4.35F-MEDICATION ADMINISTRATION CONSENT FORM**

Student's Name (Please print): \_\_\_\_\_

This form is good for the school year 2024-2025. This consent form must be updated anytime the student's medication order changes and renewed each year and/or anytime a student changes schools.

Medications, including those for self-administration, must be in the original container and be properly labeled with the student's name, the ordering provider's name, the name of the medication, the dosage, frequency, and instructions for the administration of the medication (including times). Additional information accompanying the medication shall state the purpose of the medication, its possible side effects, and any other pertinent instructions (such as special storage requirements) or warnings.

I hereby authorize the school nurse, or designee, to administer the following medication to my student:

Name of medication: \_\_\_\_\_

Name of a prescribing healthcare provider: \_\_\_\_\_

Dosage: \_\_\_\_\_

Instructions for administering the medication: \_\_\_\_\_

\_\_\_\_\_

Other instructions: \_\_\_\_\_

\_\_\_\_\_

I hereby authorize \_\_\_\_\_ to administer the above medication to my student in the unavailability of the school nurse at school in accordance with the above medication administration instructions.

I authorized the school nurse to take a photograph of my student to be used to verify my student's identification before the school nurse or an authorized individual administers medications to my student.

I acknowledge that the District, its Board of Directors, and its employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent form.

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

**4.35F5-ALBUTEROL EMERGENCY ADMINISTRATION CONSENT FORM**

Student's Name (Please print): \_\_\_\_\_

This consent form must be updated anytime the student's medication order changes and renewed each year and/or anytime a student changes schools.

My child has an IHP that provides for the administration of albuterol in emergencies. I hereby authorize the school nurse or other school employee certified to administer albuterol to administer albuterol in emergencies when he/she believes my child is in perceived respiratory distress.

The medication must be in the original container and be properly labeled with the student's name, the ordering provider's name, the name of the medication, the dosage, frequency, and instructions for the administration of the medication (including times). Additional information accompanying the medication shall state the purpose of the medication, its possible side effects, and any other pertinent instructions (such as special storage requirements) or warnings.

Date of healthcare provider's order: \_\_\_\_\_

Circumstances under which albuterol may be administered: \_\_\_\_\_

\_\_\_\_\_

Other instructions: \_\_\_\_\_

\_\_\_\_\_

I acknowledge that the District, its Board of Directors, and its employees shall be immune from civil liability for damages resulting from the administration of albuterol per this consent form, District policy, and Arkansas Law.

Parent or legal guardian signature: \_\_\_\_\_

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

Date Adopted: June 2019

Last Revised: July 2024

*Relates to Board Policy 4.35*

**4.35F4-EPINEPHRINE EMERGENCY ADMINISTRATION CONSENT FORM**

Student's Name (Please Print): \_\_\_\_\_

This form is good for the school year 2024-2025. This consent form must be updated anytime the student's medication order changes and renewed each year and/or anytime a student changes schools.

My child has an IHP that provides for the administration of epinephrine in emergency situations. I hereby authorize the school nurse or other school employee certified to administer auto-injectable epinephrine to administer auto-injectable epinephrine in emergency situations when he/she believes my child is having a life-threatening anaphylactic reaction.

The medication must be in the original container and be properly labeled with the student's name, the ordering provider's name, the name of the medication, the dosage, frequency, and instructions for the administration of the medication (including times). Additional information accompanying the medication shall state the purpose for the medication, its possible side effects, and any other pertinent instructions (such as special storage requirements) or warnings.

Date of physician's order: \_\_\_\_\_

Circumstances under which Epinephrine may be administered: \_\_\_\_\_

\_\_\_\_\_

Other instructions: \_\_\_\_\_

\_\_\_\_\_

I acknowledge that the District, its Board of Directors, and its employees shall be immune from civil liability for damages resulting from the administration of auto-injector epinephrine per this consent form, District policy, and Arkansas Law.

Parent or legal guardian signature: \_\_\_\_\_

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

Date Revised: July 2024

*Relates to Board Policy 4.35*

**4.35 – GLUCAGON ADMINISTRATION AND CARRY CONSENT FORM**

Student's Name: \_\_\_\_\_

The student has developed Section 504 Plan acknowledging that my child has been diagnosed with Type I diabetes. The 504 Plan authorizes the school nurse or, in the absence of the nurse, trained volunteer district personnel, to administer Glucagon in an emergency situation with my child.

I hereby authorize the school nurse or, in the absence of the nurse, trained volunteer district personnel designated as care providers, to administer Glucagon to my child in an emergency situation. Glucagon shall be supplied to the school nurse by the student's parent or guardian and shall be in the original container.

I acknowledge that the District, its Board of Directors, its employees, its employees, or an agent of the District including a healthcare professional who trained volunteer school personnel designated as care providers shall not be liable for any damages resulting from his/her actions or inactions in the administration of Glucagon per this consent form and the 504 Plan.

Parent or legal guardian signature: \_\_\_\_\_

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

Volunteer signature: \_\_\_\_\_

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

Date Adopted: June 2012

*Relates to Board Policy 4.35*

**4.35F6-Stress and Emergency Dose Medication Administration Consent Form**

Student's Name (Please Print) \_\_\_\_\_

This form is good for the school year 2024-2025. This consent form must be updated anytime the student's medication order changes and renewed each year and /or anytime a student changes school.

The school has developed an individual health plan (IHP) acknowledging that my child has been diagnosed as suffering from adrenal insufficiency. The IHP authorizes the school nurse to administer a stress or emergency dose medication to my child in an emergency.

Date of healthcare provider's order \_\_\_\_\_

Circumstances under which the stress or emergency dose medication may be administered

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Other instructions \_\_\_\_\_

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In the absence of the nurse, trained volunteer district personnel may administer a stress dose or emergency dose medication to my child in an emergency.

I hereby authorize the school nurse to administer a stress or emergency dose medication to my child, or, in the absence of the nurse, trained volunteer district personnel designated as care providers, to administer the stress or emergency dose medication to my child in an emergency. I will supply the stress or emergency dose medication to the school nurse in the original container properly labeled with the student's name, the ordering provider's name, the name of the medication, the dosage, frequency, and instructions for the administration of the medication (including times). Additional information accompanying the medication shall state the purpose for the medication, possible side effects, and any other pertinent instructions (such as special storage requirements) or warnings.

I acknowledge that the District, its Board of Directors, its employees, or an agent of the District, including a healthcare professional who trained volunteer school personnel designated as care providers shall not be liable for any damages resulting from his/her actions or inactions in the administration of the stress or emergency dose medication per this consent form and the IHP.

Parent or legal guardian signature \_\_\_\_\_

Date Adopted: June 2021

Last Revised: July 2024

*Relates to Board Policy 4.35*

4.35F7 – Stress Dose Medication Self-Administration Consent Form

Student’s Name (Please Print) \_\_\_\_\_

This form is good for the school year 2024-2025. This consent form must be updated anytime the student’s medication order changes and renewed each year and/or anytime a student changes schools.

The following must be provided for the student to be eligible to self-administer a stress dose medication. Eligibility is **only** valid for this school for the current academic year.

- A written statement from a licensed health-care provider who has prescriptive privileges that he/she has prescribed the stress dose medication for the student and that the student needs to carry the medication on his/her person due to a medical condition;
- the specific medications prescribed for the student;
- an individualized health care plan developed by the prescribing health-care provider containing the treatment plan for managing adrenal insufficiency of the student and for medication use by the student during school hours; and
- A statement from the prescribing health-care provider that the student;
  - Possesses the skill and responsibility necessary to use and administer the stress dose medication; and
  - Has been instructed on the details of his or her medical condition and the events that may lead to an adrenal crisis.

If the school nurse is available, the student shall demonstrate his/her skill level in administering the stress dose medication to the nurse.

Stress dose medication for a student’s self-administration shall be supplied by the student’s parent or guardian and be in the original container properly labeled with the student’s name, the ordering provider’s name, the name of the medication, the dosage, frequency, and instructions for the administration of the medication (including time). Additional information accompanying the medication shall state the purpose of the medication, its possible side effects, and any other pertinent instructions (such as special storage requirements) or warnings.

Students who self-carry stress dose medications shall also provide the school nurse with a dose of the stress dose medication to be used in emergencies.

I understand this form authorizes my student to possess and use the medication included on this form while on school grounds and at school-sponsored events but that distribution of the medication included on this form to other students may lead to disciplinary action against my student.

My signature below is an acknowledgment that I understand that the District, its Board of Directors, and its employees shall be immune from civil liability for injury resulting from the self-administration of medications by the student named above.

Parent or legal guardian signature \_\_\_\_\_ Date \_\_\_\_\_

*Relates to Board Policy 4.35*



**4.41-OBJECTION TO PHYSICAL EXAMINATIONS OR SCREENINGS**

I, the undersigned, being a parent or guardian of a student, or a student eighteen (18) years of age or older, hereby note my objection to the physical examination or screening of the student named below.

Physical examination or screening being objected to:

\_\_\_\_\_ Vision test (PreK, K, 1<sup>st</sup>, 2<sup>nd</sup>, 4<sup>th</sup>, 6<sup>th</sup>, 8<sup>th</sup> & all transfer students are screened)

\_\_\_\_\_ Hearing test (PreK, K, 1<sup>st</sup>, 2<sup>nd</sup>, 4<sup>th</sup>, 6<sup>th</sup>, 8<sup>th</sup>, & all transfer students are screened)

\_\_\_\_\_ Scoliosis test (6<sup>th</sup> grade girls only & both boys and girls in 8<sup>th</sup> grades are screened)

\_\_\_\_\_ Height/Weight measurements (BMI) (K, 2<sup>nd</sup>, 4<sup>th</sup>, 6<sup>th</sup>, 8<sup>th</sup>, & 10<sup>th</sup> grades are measured)

\_\_\_\_\_ other, please specify

Comments:

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Name of student (Printed)

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Signature of parent (or student, if 18 or older)

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Date form was filed (To be filled in by office personnel)

*Relates to Board Policy 4.41*

**5.6-REQUEST FOR RECONSIDERATION OF INSTRUCTIONAL**

**SUPPLEMENT MATERIALS, EVENTS, AND ACTIVITIES**

Name: \_\_\_\_\_

Date submitted: Level one \_\_\_\_ level two \_\_\_\_ level three \_\_\_\_

Instructional material, event, or activity being contested:

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Reason(s) for contesting the material, event, or activity (be specific):

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Signature of receiving principal: \_\_\_\_\_

Signature of curriculum coordinator: \_\_\_\_\_

Signature of superintendent: \_\_\_\_\_

**5.7-REQUEST FOR RECONSIDERATION FORM**

**OF LIBRARY/MEDIA CENTER MATERIAL**

Name: \_\_\_\_\_

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

Media Center material being contested:

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Reason(s) for contesting the material (Be specific about why you believe the material does not meet the selection criteria listed in board policy 5.7—Selection of Library/Media Center Material):

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What is your proposed resolution?

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Signature of receiving principal: \_\_\_\_\_

Signature of superintendent (if appealed): \_\_\_\_\_

*Relates to Board Policy 5.7*

**5.20F-PERMISSION TO DISPLAY PHOTO OF STUDENT ON WEBSITE**

I hereby grant permission to the Nemo Vista School District to display the photograph or video clip of my student (if the student is under the age of eighteen [18]) on the District's website, including any page on the site, or in other District publications without further notice. I also grant the Nemo Vista School District the right to edit the photograph or video clip at its discretion.

The student's name may be used in conjunction with the photograph or video clip. It is understood, however, that once the photograph or video clip is displayed on a website, the District has no control over how the photograph or video clip is used or misused by persons with computers accessing the District's website.

\_\_\_\_\_

Name of student (printed)

\_\_\_\_\_

Signature of the student (only necessary if the student is over 18)

\_\_\_\_\_

Signature of parent (required if the student is under 18)

Date\_\_\_\_\_

*Relates to Board Policy 5.20.1*

**PERMISSION TO DISPLAY STUDENT INFORMATION ON WEB SITE**

**Board Policy 5.20.2**

I hereby grant permission to the Nemo Vista School District to display me/my student's name (if the student is under the age of eighteen (18) in conjunction with me/my student's home address, email address, telephone number, and/or my parents' names.

It is understood, however, that once the information is displayed on a website, the District has no control over how the information is used or misused by persons with computers accessing the District's website.

I (we) agree to defend and hold harmless the members of the Nemo Vista School Board, the Nemo Vista School District, its officers, employees, agents, successors, and assignees from and against any claims and liabilities resulting from displaying me/my student's specified information.

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Name of student (Printed)

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Signature of the student (only necessary if the student is over 18)

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Signature of parent (required if the student is under 18)

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Date

*Relates to Board Policy 5.20.2*

**5.24F2-PERMISSION TO PARTICIPATE IN A SURVEY, ANALYSIS, OR EVALUATION**

I, the undersigned, being a parent or guardian of a student, or a student eighteen (18) years of age or older, hereby grant my permission for the student named below to participate in the following survey, analysis, or evaluation.

Name of Survey \_\_\_\_\_

\_\_\_\_\_

Name of student (Printed)

\_\_\_\_\_

Signature of parent (or student, if eighteen (18) or older)

\_\_\_\_\_

Date form was filed (To be filled in by office personnel)

Revised Date: July 2024

*Relates to Board Policy 5.24*

**5.24F—OBJECTION TO PARTICIPATION IN SURVEYS, ANALYSIS, OR EVALUATIONS**

I, the undersigned, being a parent or guardian of a student, or a student eighteen (18) years of age or older, hereby note my objection to participation by the student named below in the following survey, analysis, or evaluation.

I choose not to have my student participate in the following survey, analysis, or evaluation.

Name of specific survey \_\_\_\_\_

\_\_\_\_ All surveys

\_\_\_\_\_

Name of student (Printed)

\_\_\_\_\_

Signature of parent (or student, if eighteen (18) or older)

\_\_\_\_\_

Date form was filed (To be filled in by office personnel)

Revised Date: July 2024

**5.17F— HONOR ROLL AND GRADUATE OPT OUT FORM**

I, the undersigned, being a parent or guardian of a student, or a student eighteen (18) years of age or older, hereby note my objection to having the student named below publicly identified as an honor roll or honor graduate student.

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Name of student (Printed)

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Signature of parent (or student, if eighteen (18) or older)

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Date form was filed (To be filled in by office personnel)

Date Revised: July 2024



**4.56.2F--- HOME-SCHOOLED STUDENTS' LETTER OF INTENT TO PARTICIPATE  
IN AN EXTRACURRICULAR ACTIVITY AT THE RESIDENT DISTRICT**

Student's Name (Please Print): \_\_\_\_\_

Parent or Guardian's Resident Address

Street: \_\_\_\_\_

Student's date of birth: \_\_\_/\_\_\_/\_\_\_

Last grade level the student completed: \_\_\_\_\_

The student has demonstrated academic eligibility by obtaining a verifiable minimum test score of the 30<sup>th</sup> percentile or better in the previous 12 months of the Stanford Achievement Test Series, Tenth Edition, or another nationally Recognized norm-referenced test approved by the State Board of Education.

Name of test, Date taken, and score achieved: \_\_\_\_\_

Extracurricular activity (is) the student requests to participate in: \_\_\_\_\_

\_\_\_\_\_

Course(s) the student requests to take at the school: \_\_\_\_\_

Proof of identity: \_\_\_\_\_

Date Submitted: \_\_\_/\_\_\_/\_\_\_

Parent's Signature: \_\_\_\_\_

Date Adopted: June 2017

*Relates to School Board Policy 4.56.2*

**4.56.2F2---HOME-SCHOOLED STUDENTS' LETTER OF INTENT TO PARTICIPATE  
IN AN EXTRACURRICULAR ACTIVITY AT NON-RESIDENT DISTRICT**

Student's Name (Please Print): \_\_\_\_\_

Parent or Guardian's Resident Address:

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Student's date of birth: \_\_/\_\_/\_\_ Last grade level the student completed: \_\_\_\_\_

The student has demonstrated academic eligibility by obtaining a verifiable minimum test score of the 30<sup>th</sup> percentile or better in the previous 12 months on the Stanford Achievement Test Series, Tenth Edition, or another nationally recognized norm-referenced test approved by the State Board of Education.

Name of test, Date taken, and score achieved: \_\_\_\_\_

Extracurricular activity (ies) the student requests to participate in: \_\_\_\_\_

Course(s) the student requests to take at the school: \_\_\_\_\_

Proof of identity: \_\_\_\_\_

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

Parent's Signature: \_\_\_\_\_

As the superintendent of the above student's resident district, I agree that the above student may participate in extracurricular activities at Nemo Vista School District.

Resident Superintendent's Signature: \_\_\_\_\_

As the superintendent of the Nemo Vista School District, where the above student desires to participate in extracurricular activities, I agree to allow the student to participate in extracurricular activities at the Nemo Vista School District.

Non-resident Superintendent's Signature: \_\_\_\_\_

Date Adopted: June 2017

*Relates to School Board Policy 4.56.2*

4.50-School Meal

CERTIFICATION OF DISABILITY

For Special Dietary Needs

Part I (to be completed by the school)

Student's Name: _____	Age: _____
School Name and Address: _____ _____	
School District: _____	
School Principal: _____	Phone: _____
Teacher: _____	Food Service Manager: _____
Other Team Members: _____	

Part II (to be completed by a licensed physician)

A student with a disability as defined by the Federal regulations for child nutrition programs is one who has a "physical, mental impairment which substantially limits one or more major life activities such as, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."		
Patient's Name: _____		
Diagnosis: _____ _____ _____		
Describe the patient's disability and check the major life activities affected by the disability: _____		
_____ Caring for one's self	_____ seeing	_____ breathing
_____ performing manual tasks	_____ hearing	_____ learning
_____ walking	_____ speaking	_____ working
_____ other: _____		
Does the disability restrict the individual's diet? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list the food(s) to be omitted, substituted, requiring texture changes, or caloric modification.		

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
<b>Date</b>	<b>Signature</b>

**Part III (optional to be completed when appropriate by a licensed Registered Dietitian (RD), Nurse (RN), or other health care team member).**

<b>Instructions given to parents regarding child's nutritional needs:</b>
_____
_____
_____
<b>List the nutrition materials given to parents for school use:</b>
_____
_____
_____
_____
<b>Describe the special feeding device(s) needed:</b>
_____
_____
_____
<b>Describe the feeding assistance needed:</b>
_____
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_____
<b>Specify special dining area requirements:</b>

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**Specify any special food preparation and storage needs:**

**(i.e., tube feeding blended in an approved food preparation area with attention paid to maintaining the product below 45 and above 140 degrees.)**

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**Signature of RD, RN, and/or**

**Health Care Team Member**

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**Date**

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**Facility of Agency**

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**Phone Number**

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**Mailing Address**

**4.5F—SCHOOL CHOICE CAPACITY RESOLUTION**

Whereas:

- The Board of Directors of the Nemo Vista School District has approved by a vote of the Board, the following capacity resolution for school choice applicants for the 2024-2025 school year under the provisions of policy 4.5—SCHOOL CHOICE and applicable Arkansas law.
- Except for applicants who are transferring under Uniformed Service Member Dependent School Choice, applicants, whose applications meet the provisions of policy 4.5—SCHOOL CHOICE will be sent a provisional acceptance notification letter, which will give instructions on the necessary steps and timelines to enroll in the District. Provisional acceptance shall be determined before July 1 with a final decision to be made by July 1 based on the district's available capacity for each academic program, class, grade level, and individual school.
- Applications will not be accepted if the applications:
  - Are received, electronically timestamped, or postmarked before January 1, unless the application is from a student who is transferring under Uniformed Service Member Dependent School Choice;
  - Are received, electronically timestamped, or postmarked after May 1, unless the application is postmarked before May 1 or is from a student who is transferring under Uniformed Service Member Dependent School Choice;
  - Are to a student's resident district that has been determined by the Division of Elementary and Secondary Education to be exempt due to an existing desegregation order; or
  - The student is transferring under Uniformed Service Member Dependent School Choice and the application is not accompanied by relevant documentation.
- The district reserves to itself the ability to determine, based on an examination of student records obtained from the prior district, and other information, whether any student would require a different class, course, or course, program of instruction, or special services than originally applied for. If such an examination determines that capacity has been reached in the appropriate class, course, or program of instruction, or that additional staff would have to be hired for the applicant, the District shall rescind the original provisional acceptance letter and deny the Choice transfer for that student.
- The district reserves to itself the ability to decline to accept under school choice any student whose acceptance would require the district to add additional staff to exceed the District's current grade, program, or building capacity.

THEREFORE, let it be resolved that these shall constitute the School Choice openings at the beginning of the School Choice enrollment period for the school year 2024-2025.

\_\_\_\_\_  
Board President

\_\_\_\_\_  
Board Secretary

\_\_\_\_\_  
Date

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

#### 4.5F2--SCHOOL CHOICE PROVISIONAL ACCEPTANCE LETTER

Dear Parents of:

The application you submitted for your child has been provisionally accepted. While the Nemo Vista School District looks forward to welcoming your child as a student, to further the application process and to better assist the district in determining the proper placement of your child, please submit the information listed below to Nemo Vista School District by \_\_\_\_\_. Failure to submit the information requested by the date specified shall void and nullify this letter's provisional acceptance. In addition to the information you submit, records may be requested from the student's current district/school, and final acceptance may depend on the content of those records as to appropriate grade placement, program placement, or services required. A student who has not previously attended an Arkansas public school or did not attend an Arkansas public school in the previous academic year may be evaluated by the district before final acceptance, and the results of that evaluation could affect final acceptance.

1. For students applying to enroll in first grade or higher: a copy of the student's transcript from the school where the student is currently enrolled. The student's permanent record, including the original transcript, will be requested from the school immediately following the student's actual enrollment in our district.
2. Proof of the student's age; This can be a:
  - a. birth certificate;
  - b. A statement by the local registrar or a county recorder certifying the child's date of birth;
  - c. An attested baptismal certificate;
  - d. A passport;
  - e. An affidavit of the date and place of birth by the child's parent or guardian;
  - f. United States military identification; or
  - g. Previous school records.
3. The student's health care needs at school.
4. Student's age-appropriate immunization record or an exemption granted for the previous school year and a statement of whether or not the parent intends to continue the exemption for the upcoming school year.

After reviewing the submitted documentation, the District will determine if the applicant meets the District's capacity standards and notify you of its decision by \_\_\_\_\_.

Respectfully,

Logan Williams,  
Superintendent

Revised: July 2024

**4.5F3—SCHOOL CHOICE ACCEPTANCE LETTER**

Dear Parents of:

I am pleased to inform you that the application you submitted for \_\_\_\_\_ has been accepted pending enrollment of your child by \_\_\_\_\_, however, failure to enroll \_\_\_\_\_ by this date will render this offer of acceptance null and void.

I look forward to welcoming \_\_\_\_\_ as part of the Nemo Vista School District.

Once your child has enrolled in school with us this coming school year, the student's name will be eligible to continue enrollment in the district until completing high school or is beyond the legal age of enrollment provided the student meets the applicable statutory and District policy requirements all other District students must meet (except residency in the District) to continue District enrollment. This information is contained in the student handbook.

Respectfully,

Logan Williams,  
Superintendent



**4.5F4--SCHOOL CHOICE REJECTION LETTER**

Dear Parents of:

I am sorry, but the application you submitted for \_\_\_\_\_ has been rejected for the following reason(s).

\_\_\_\_ Your child's resident district has declared itself exempt from the provisions of the School Choice Law due to it being under an enforceable desegregation order.

\_\_\_\_ Your child does not meet the openings identified for the coming school year identified in the Board of Directors Resolution adopted on insert date.

The specific reason for rejection is that acceptance would cause the district to have to add:

\_\_\_ Staff

\_\_\_ Teachers

\_\_\_ classroom(s)

\_\_\_ the insert the name of the program, class, grade level, or school building's capacity

As noted in your original application, you have ten (10) days from receipt of this notice in which to submit a written appeal of this decision to the State Board of Education.

Respectfully,

Logan Williams,

Superintendent

The Nemo Vista Handbook serves as a guide to foster a positive, respectful, and productive learning environment. By adhering to the policies outlined, we can remain a place where all students, staff, and families feel valued and supported.

These policies promote safety, academic excellence, and personal growth, while encouraging mutual respect and responsibility within the school and community.

As our school continues to grow and evolve, we recognize that policies may need to be reviewed and updated to meet the changing needs of the students and state requirements. While there are many policies are set by the state department, we encourage ongoing feedback and collaboration to ensure they remain effective and reflect the values of our school. The goal is to create an environment where everyone thrives and achieves their fullest potential. We appreciate your commitment to upholding these standards and contributing to the success of Nemo Vista Schools.