Important forms needing your signature are included.
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Vision and Mission

The vision of Charlotte-Mecklenburg Schools is to lead the community in educational excellence, inspiring intellectual curiosity, creativity, and achievement so that all students reach their full potentials.

The mission of Charlotte-Mecklenburg Schools is to create an innovative, inclusive, student-centered environment that supports the development of independent learners.

In compliance with Federal Law, Charlotte-Mecklenburg Schools administers all education programs, employment activities and admissions without discrimination against any person on the basis of gender, race, color, religion, national origin, age, or disability. Inquiries regarding compliance with Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex in education programs or activities, may be referred to the District’s Title IX Coordinator at titleixcoordinator@cms.k12.nc.us or to the Office for Civil Rights, United States Department of Education.

Charlotte-Mecklenburg Schools also provides accessibility as required by the Americans with Disabilities Act (ADA). If auxiliary aids for communication are necessary for participation in a CMS program or service, please notify the district’s ADA coordinator at least one week before the program or service begins. Call 980-343-6661 or email accessibility@cms.k12.nc.us.
Agreement for Students Enrolled in CMS

Charlotte-Mecklenburg Schools teachers and administrators are committed to providing students with textbooks/technology devices during the first 10 days of school. We are committed to working together to promote a sound and positive teaching and learning experience for each student. This contract is an agreement to work in partnership to ensure the successful attainment of our mutual goal.

As a student, I pledge to

- use textbooks/technology devices appropriately
- avoid damaging and losing textbooks/technology devices
- pay for textbooks/technology devices that I damage or lose

Student signature: __________________________ Date: __________________________

As a parent/guardian of __________________________, I pledge to

- encourage appropriate use of textbooks/technology devices and monitor the textbooks/technology devices my child brings home from school
- support the school staff in their efforts to provide my child with the textbooks/technology devices needed for learning
- monitor the textbooks/technology devices my child brings home from school
- encourage my child to be responsible for the proper use of the textbooks/technology devices
- return textbooks/technology devices at the end of the year, or if my child moves to another school within or outside the district
- pay for textbooks/technology devices that are damaged or lost

Parent/Guardian signature: __________________________ Date: __________________________

As a teacher, I pledge to

- explain my expectations and instructional goals to students and parents during orientation and throughout the year
- assign textbooks/technology devices to students being careful to evaluate the book/device before issuing it to the student
- provide a challenging, caring, learning environment, using the textbook/technology as a teaching tool to support the North Carolina Standard Course of Study
- maintain accurate records on textbooks/technology devices
- collect and issue a receipt for lost and/or damaged textbooks/technology devices

Homeroom Teacher signature: __________________________ Date: __________________________

The principal, as the instructional leader of the school, is committed to providing your child with the textbooks and technology needed to support the North Carolina Standard Course of Study. Parental involvement is essential as we work to give your child the best educational experiences possible.

FOR SCHOOL USE ONLY

Issued Textbooks for the _____ - _____ School Year

<table>
<thead>
<tr>
<th>Subject</th>
<th>Course #</th>
<th>Title</th>
<th>Book #</th>
<th>Condition</th>
<th>Cost</th>
<th>Teacher #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
<td></td>
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<tr>
<td>5.</td>
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<tr>
<td>6.</td>
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<td></td>
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<tr>
<td>7.</td>
<td></td>
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<tr>
<td>8.</td>
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</tr>
</tbody>
</table>

Technology Devices will be assigned to the student in the district inventory system.
STUDENT LOCKER ASSIGNMENT
(GRADES 6-12)

Lockers are the property of the district. They should only contain supplies needed for school and are subject to authorized searches at any time, including sniff inspections done by specially trained dogs, as permitted by CMS Board Policy JIHD.

Student signature:________________________________________________________________________________________

Parent/Guardian signature:________________________________________________________________________________

School:________________________________________________________________ No. of locker assigned:________________________

Date assigned:________________________ Date:________________________________________

Assigned by:________________________________________________________________ Locker combination:________________________

PARTICIPATION IN PHYSICAL EDUCATION
(GRADES K-12)

All students shall participate in physical education. No student shall be permitted to waive or substitute other classes for the physical education requirement except as follows: Suitably adapted physical education shall be included as part of the Individualized Education Program for students with a chronic health problem, other disabling conditions, or other special needs that preclude following the Physical Education portion of the Essential Standards: IDEA: http://goo.gl/1Tuik.

Name of student:________________________________________________________________________________________

Teacher:________________________________________________________________ Grade:________________________

School:________________________________________________________________________________________

Please Check One:

☐ My child is able to fully participate in physical education
☐ I would like the physical education teacher to be aware of the following health concerns (e.g., diabetes, allergic reactions, asthma, heart conditions) that may require modifications or a specially designed physical education program:

________________________________________________________________________________________

________________________________________________________________________________________

Parent/Guardian signature:________________________________________ Date:______________________

Please complete form and return to your student’s school.
I grant Charlotte-Mecklenburg Schools the unlimited right to use and/or reproduce photographs*, likenesses or the voice of my child in any legal manner and for the internal or external promotional and informational activities of Charlotte-Mecklenburg Schools. I also agree to allow my child to be interviewed and/or photographed* by representatives of the external news media, school staff and CMS Communications Services in relation to any and all coverage of Charlotte-Mecklenburg Schools in which he/she is involved. I also agree to allow my child's work and/or photograph* to be published in any CMS communication, including web and intranet sites, social and broadcast media channels and print and electronic publications. I further understand that by signing this release, I waive any and all present or future compensation rights to the use of the above stated material(s) including, print, electronic and online media.

School name: ______________________________________________________________________________________________________

Student’s name: _________________________________________________________ Homeroom teacher: __________________________

Parent/Guardian signature: ________________________________________________ Date: _____________________________________

Parent/Guardian name (Print): _________________________________________________________________________________________

Parent/Guardian address: _____________________________________________________________________________________________

* “Photograph” in this Release Form is intended to only refer to photos and videos of your child alone. Group photographs and videos (two or more children), with no additional identifying information, are considered Directory Information. Please review the FERPA information sheet in the Parent-Student Handbook.

This information to be completed by school officials only.

Your Name: ____________________________________________________________ Date: _________________________________

Type of Material

- Photograph
- Slide
- Videotape
- Other (please specify) ____________________________________________________________________________

Use of Material

(Please provide additional information such as name of news outlet, brochure, purpose of presentation, etc.)

- News outlet
- CMS website/Intranet site
- Brochure
- PowerPoint presentation

Form # 6162.5 | 7/2021  Please complete form and return to your student’s school.
Students enrolled in instrumental music (band or strings) must complete this form.

**Instrument Storage Areas**

*If necessary,* individual schools may provide storage areas where instruments may be kept overnight. These storage areas are not individual lockers, but open shelving areas. Since students have access to these areas as well as other areas of campus, the Charlotte-Mecklenburg Board of Education assumes no responsibility for any loss or damage to any instrument stored at these locations, on buses or at bus stops.

**School-Owned Instruments**

Before a school owned instrument can be assigned to the student, parents or guardians must complete a *Music Instrument Loan Form,* stating students are *financially responsible for the instrument beyond normal wear and tear.* This form can be obtained from the instrumental music teacher.

**Instrument Changes**

All changes of instruments are at the discretion of the music director.

**Instrument Repair**

If a student-owned instrument needs repair, it should be taken to an instrument repair shop in a timely manner. Please provide a written note or email from parent or guardian with the name of the repair shop, the date the instrument was taken in and when it is expected to be returned so that your child’s grade will not be affected. School-owned instruments needing repair should be brought directly to the music director’s attention.

Name of school: ____________________________________________________________

(Please print)

Student name: ____________________________________________________________

(Please print)

Parent/Guardian signature: ________________________________________________  Date: _____________________________________
MEDICATION AUTHORIZATION FOR CMS STUDENTS

<table>
<thead>
<tr>
<th>School Name</th>
<th>School Phone #</th>
<th>For School Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Date Received/Receiver’s Signature:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication Received? [ ] yes [ ] no</td>
</tr>
</tbody>
</table>

If submitting by fax: 704-432-2079 (School Health)

<table>
<thead>
<tr>
<th>Student’s Name (Please print.)</th>
<th>Student’s Date of Birth</th>
<th>Date Approved/Nurse’s Signature</th>
</tr>
</thead>
</table>

Entered in EHR? [ ] yes [ ] no

Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school (CMS Policy JLCD/Regulation JLCD-R). Contact the school nurse for help if relocating from another state with orders from an out-of-state provider. Some medications may not be suitable for a school setting. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Contact the school nurse if you have questions.

SECTION 1: LICENSED HEALTHCARE PROVIDER AUTHORIZATION

- When possible, medications should be taken before or after school. Administration of non-prescription medications at school is discouraged.
- CMS action plans for asthma, diabetes, seizure disorders and severe allergies may be used instead of this form. See CMS Coordinated School Health webpage.
- When using this form, complete a separate form for each medication; write legibly; use lay terms.
- Complete Section 3 for students who will self-carry and/or self-medicate.

<table>
<thead>
<tr>
<th>Medication: (Generic/Brand)</th>
<th>Controlled Substance? [ ] yes [ ] no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose/Dosing Instructions:</td>
<td>Route:</td>
</tr>
<tr>
<td>Administration Time:</td>
<td>[ ] PRN (specify time interval):</td>
</tr>
<tr>
<td>Relationship to meals:</td>
<td>[ ] Not applicable [ ] With meals [ ] With snacks</td>
</tr>
<tr>
<td></td>
<td>[ ] Other:</td>
</tr>
<tr>
<td>Purpose:</td>
<td>Check here if this medication is to be used for emergencies only. [ ]</td>
</tr>
<tr>
<td>Side Effects/Adverse Reactions:</td>
<td></td>
</tr>
<tr>
<td>Anticipated length of treatment:</td>
<td>[ ] School Year [ ] ______ Months [ ] ______ Weeks [ ] ______ Days</td>
</tr>
<tr>
<td>Other Instructions (including emergency situations):</td>
<td></td>
</tr>
</tbody>
</table>

In my professional opinion, it is medically necessary for this student to receive this medication during school hours.

Signature of Healthcare Provider: __________________________ Date: ______________________

Stamp, Print or Type Healthcare Provider’s Name & Address

Office Phone

Office Fax

SECTION 2: PARENT / LEGAL GUARDIAN CONSENT

- I understand: No medication will be given at school until this authorization has been approved by a school nurse. New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. It is my responsibility to supply the medication. Each medication must be in the original labeled container from the pharmacy or healthcare provider’s office. Some pharmacies will provide an extra container for school use. Information about this medication and my child’s health may be shared with school staff or agents of the school to help assure my child’s safety and success at school. The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and my child’s health. Medications are given by a nurse or trained CMS staff.
- I give permission for my child to receive the medication described above during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about this medication and my child’s health.
- On behalf of my child, I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.

Parent/Legal Guardian Signature: __________________________ Date: ______________________

Phone Numbers (mobile, work, home):

Parent/Legal Guardian (Print Name):
SECTION 3: AUTHORIZATION FOR SELF-MEDICATION BY CMS STUDENTS

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>Student’s Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Purpose of Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CMS ELIGIBILITY REQUIREMENTS FOR SELF-MEDICATION

Students with chronic conditions such as asthma, diabetes, severe allergies and those who require frequent doses of non-prescription products, may be eligible to self-medicate. Self-administration of a controlled substance will be considered in rare instances where potentially harmful medical episodes may occur. For self-medication, students: 1) must be mentally, emotionally, and physically capable of self-administering medication, 2) must have been instructed in proper use and safe-keeping of their medications, 3) must demonstrate mature and responsible behavior using their medication 4) must keep their medication secure on their own person or in some other manner agreed upon with the school nurse and the school administration, and 5) must not share medication with or display to other students. The privilege of being allowed to self-medicate may be taken away if there is any just cause. Failure to follow CMS policies and regulations may result in disciplinary actions as noted in the Student Code of Conduct. The CMS Board of Education, its designees and agents, do not assume responsibility for self-medication by students. Additional details are noted in CMS Policy JLCD/Regulation JLCD-R.

HEALTHCARE PROVIDER

The student named above meets the CMS eligibility requirements for self-medication. This student is capable of, has been instructed on the procedures for and has demonstrated the skill to self-administer this medication as directed in Section 1 of this form. This student will not require adult supervision while taking this medication.

Is this medication a controlled substance? ☐ yes ☐ no

Check applicable items below:
☐ Please allow this student to self-administer this medication while at school during school hours.
☐ This student should carry this medication with him/her at all times during the school day, while at school-sponsored events, or while in transit to or from school or school-sponsored activities.

Healthcare Provider Signature: __________________________ Date: _______________

Healthcare Provider (Print Name): __________________________

PARENT/LEGAL GUARDIAN

My child is capable of self-medicating and meets the CMS eligibility requirements. I give consent to the Charlotte-Mecklenburg Schools to allow my child to self-administer this medication at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medication. If this medication is for a life-threatening emergency such as anaphylaxis or asthma, I agree to provide a backup supply of the medication to be kept at school in a location to which my child has immediate access to assure the medication is available if needed. I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child carrying or taking this medication at school. I understand that information about this medication and my child’s health may be shared with other school staff and agents of the school to help assure my child’s safety and success at school. The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and my child’s health.

Parent/Legal Guardian Signature: __________________________ Date: _______________

Parent/Legal Guardian (Print Name): __________________________

STUDENT

I am capable of taking this medication on my own. I agree to take this medication as ordered. I will keep it safe and out of the sight of others when I am not using it. I will not let others hold or use my medication or medical supplies. I understand that I will be disciplined under the CMS Student Code of Conduct if I abuse the privilege of being allowed to self-medicate while at school or school sponsored activities. I understand that I may lose the privilege of self-administering my medication if I do not follow these rules.

Student Signature: __________________________ Date: _______________

Student (Print Name): __________________________

SCHOOL NURSE

I have reviewed this request and acknowledge that this student has demonstrated the skill level to self-administer this medication. I have informed this student that he or she must tell an appropriate staff member whenever he or she has used the medication at school.

Nurse Signature: __________________________ Date: _______________

Nurse (Print Name): __________________________

PRINCIPAL / DESIGNEE

I have reviewed this request and approve this student for self-administering this medication.

Principal/Designee Signature: __________________________ Date: _______________

Principal/Designee (Print Name): __________________________
<table>
<thead>
<tr>
<th>Request Type</th>
<th>School</th>
<th>Initial Diet Order</th>
<th>Meal Eaten at School</th>
<th>Grades</th>
<th>Grade</th>
<th>Meals Eaten at School</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Solicitud)</td>
<td>(Escuela)</td>
<td>(nueva)</td>
<td>(Desayuno)</td>
<td>(Grado)</td>
<td>(100% de carbohidratos)</td>
<td>(Consumirá en la escuela)</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Parent/Guardian Contact Information

<table>
<thead>
<tr>
<th>Name (Nombre)</th>
<th>Phone Number (Teléfono)</th>
<th>Mailing Address, City, State, Zip (Dirección postal, ciudad, estado, código postal)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Parent/Guardian: It is REQUIRED that this completed form be returned to CMS School Nutrition Services. This form must be completed by a state licensed healthcare professional each time student's diagnosis or change of treatment is indicated. This written statement will remain in effect until the parent or legal guardian revises such statement.

Medical Office Stamp (required for processing)

Part B COMPLETED BY THE PHYSICIAN ONLY: Complete Items 16-20 (16 al 20 – Esta sección para ser completada por el médico solamente.)

Parent/Guardian: Complete Items 1-15

Part A

Parent/Guardian: It is REQUIRED that this completed form be returned to CMS School Nutrition Services. This form must be completed by a state licensed healthcare professional each time student's diagnosis or change of treatment is indicated. This written statement will remain in effect until the parent or legal guardian revises such statement.

Parent/Guardian: Se REQUIERE que se devuelva esta planilla debidamente completada a CMS School Nutrition Services. Esta planilla tiene que ser completada por un profesional de salud con licencia estatal cada vez que ocurra un cambio de tratamiento o diagnóstico del estudiante. Esta declaración escrita permanecerá en vigencia hasta que el padre/madre/tutor revoque dicha declaración.

* Monthly menus with carbohydrate content in grams and major food allergens are posted at http://cms.nutrislice.com. A completed Diet Order Form is not required if nutrislice information is sufficient for parent/guardian to manage a student's diet at school.

<table>
<thead>
<tr>
<th>Date of Birth (Fecha de nacimiento)</th>
<th>Request Type</th>
<th>Student's Power School #/N° de estudiante</th>
<th>Student's Last Name (Apellido del estudiante)</th>
<th>Student's First Name (Nombre del estudiante)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(otro)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Description of allergies

<table>
<thead>
<tr>
<th>Allergy (alergia)</th>
<th>Medical or dietary need for this request (condición médica o dietética para esta solicitud)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fluid Milk Substitution: Available options to substitute</td>
</tr>
<tr>
<td></td>
<td>Lactaid Milk</td>
</tr>
<tr>
<td></td>
<td>Additional beverages: 100% Fruit Juice Water</td>
</tr>
<tr>
<td></td>
<td>Medical or dietary need for this request</td>
</tr>
<tr>
<td></td>
<td>Medical or dietary need for this request</td>
</tr>
</tbody>
</table>

Part B

Parent/Guardian: Complete Items 17-20 (17 al 20 – Esta sección para ser completada por el médico solamente.)

Conclusion

<table>
<thead>
<tr>
<th>Other Condition (Must be diagnosed by physician using Part B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Otra condición debe ser diagnosticada por un médico en la parte B)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diet Order</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Healthcare Provider Information

<table>
<thead>
<tr>
<th>Healthcare Provider Information</th>
<th>Form will be returned to parent / guardian and NO accommodations will be made if this section is not filled in its entirety.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Provider Signature</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Medical Office Stamp (required for processing)</td>
<td></td>
</tr>
</tbody>
</table>

USDA is an equal opportunity provider and employer.
Parents: Please return this completed form to your child’s school. In order to apply for a formula grant under the Indian Education Program, your child’s school must determine the number of Indian children enrolled. Any child who meets the following definition may be counted for this purpose. You are not required to complete or submit this form to the school. However, if you choose not to submit a form, the school cannot count your child for funding under the program. This form should be kept on file and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

**Definition:** Indian means an individual who is (1) A member of an Indian tribe or band, as membership is defined by the Indian tribe or band, including any tribe or band terminated since 1940, and any tribe or band recognized by the State in which the tribe or band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

Name of Child ___________________________________________ Date of Birth ____________________(As shown on school enrollment records) PLEASE NOTE: A separate form is required for each Indian child that is enrolled.

School Name ___________________________________________ Grade _________________________

**TRIBAL ENROLLMENT**

Name of individual with tribal enrollment: __________________________________________________________ (Individual named must be a descendent in the first or second generation)

The individual with tribal membership is the: ___ Child ___ Child’s Parent ___ Child’s Grandparent ___ Child’s Guardian

Name of tribe or band for which individual above claims membership: __________________________________________

**Tribe or Band is (select only one):**

- [ ] Federally Recognized
- [ ] State Recognized
- [x] Terminated Tribe (Documentation required. Must attach to form)
- [ ] Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994. (Documentation required. Must attach to form)

Proof of enrollment in tribe or band listed above, as defined by the tribe or band is:

A. Membership or enrollment number (if readily available) _____________________________________________ OR

B. Other Evidence of Membership in the tribe listed above (describe and match) __________________________________________________________

Name and address of tribe or band maintaining enrollment data for the individual listed above:

Name __________________________ Address __________________________

City __________________________ State __________ Zipcode __________

**ATTESTATION STATEMENT:** I verify that the information provided above is accurate:

Name Parent/Guardian________________________ Signature __________________________

Address ___________________________________ City __________ State _____ Zipcode __________

Email Address ______________________________ Date __________________________}

**NOTICE:** Public Reporting Burden Notice on next page.

Contact information for Title VI Indian Education program is also provided.

OMB Number: 1810-0021 Expiration Date: 04/30/2023
PAPERWORK BURDEN STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W203, Washington, D.C. 20202-6335.

Charlotte-Mecklenburg Schools

Please submit a copy of the completed Title VI ED Indian Student Eligibility Certification form to:

Chiquitha Lloyd
Director of Diversity & Inclusion
Title VI Indian Education Program Director

Office of the Superintendent
4421 Stuart Andrew Blvd., Suite 102
Charlotte, NC 28217
980-343-8638 - Office
980-343-7135 - Fax
Courier #835-A