Enrollment Information for New Students at Shawnee Mission North High School

This information is for parents who own or rent their residence within the Shawnee Mission North attendance area, and have utility bills in their name mailed to the address. If you will be living with someone who owns or rents the residence, and you do not receive utility bills in your name, please refer to the Residency Provider information listed in bold below.

1. Please schedule an appointment to enroll with a counselor by calling **993-6930**.
2. Please arrive 30 minutes prior to scheduled appointment time to fill out paperwork.
3. Please bring the following items to the enrollment meeting:
    a. Proof of residence. **Two** recent utility bills (gas, electric, water only) **and** current mortgage statement or rental agreement
    b. Immunization records for the student
    c. Birth certificate for the student
    d. Transcripts from previous school
    e. Driver's License – must match the residence address
    f. Withdrawal paperwork from previous school (withdrawal paperwork should include most recent grades from previous school)
    g. IEP if student is currently being served by special education services.
4. Student fees will need to be paid at the time of the enrollment which includes activity/participation fee, textbook rental, ID card.
5. Additional fees may apply depending on course selection.

This information is for parents and/or students who will be living with someone who owns or rents a residence within the Shawnee Mission North attendance area. The person providing the residence will be known as the Residence Provider.

1. A Residence Provider Affidavit packet is available in **Student Services.** The forms need to be filled out and signatures notarized prior to the meeting with the school district residency officer.
2. Schedule an appointment to meet with the district residency officer regarding the Residence Provider situation. Parent, student and person providing the residence need to attend. Please call **993-7986** to schedule this meeting.
3. Once approved, please follow steps 1-5 above to complete enrollment.

HOME LANGUAGE SURVEY

Upon enrollment, every student or parent/guardian must be given a Home Language Survey. This survey will be used to determine which students should be assessed for English proficiency. Knowledge of, or exposure to another language does not, in and of itself, qualify a student for ESOL services. If a language other than English is indicated in any of questions 1-4, the student will be assessed to determine eligibility for English for Speakers of Other Languages (ESOL) services. If a student scores below proficient/fluent in any of the language domains: listening, speaking, reading, or writing, s/he is eligible for ESOL services. Please complete one form for each child.

Student Information:

Name		Grade
Address		Date of Birth
Date first enrolled in a school in the U.S	**U.S. Entry Date**	Phone Number

Student Language Information:

1. What language did your child first learn to speak/use?
   English _____ Spanish _____ Other (please specify) _____
2. What language does your child speak/use at home?
   Do not include language learned in a class or through television or other such.
   English _____ Spanish _____ Other (please specify) _____
3. What language do you speak/use with your child?
   English _____ Spanish _____ Other (please specify) _____
4. What language do the adults regularly present or living in the home speak/use while in presence of the child?
   English _____ Spanish _____ Other (please specify) _____

Office Use Only

If any answer to questions 1-4 indicates a language other than English,

1) Contact your Reading Specialist or ELL Aide to schedule an IPT evaluation

2) Email this form to mariamcintyre@smsd.org

Parent/Guardian Information:

Which language do you prefer? English ___Spanish ___ Other (specify)_____
(Please specify "written" or "spoken". To the extent practicable, communication from the school will be provided in this language).

Migrant Education Program Information:

The Migrant Education Program (MEP) is authorized by Title I Part C of the Elementary and Secondary Education Act of 1965 (ESEA). The MEP provides formula grants to local education agencies to establish or improve education programs for children who may qualify for the Migrant Program. Please help us determine your child's eligibility for the Migrant Program by responding to the following questions.

Have you or a member of your family moved in the last 36 months to do, or apply for, agriculture or fishing related work, including dairies, nurseries, meat or vegetable processing, feed yards, or field work? Yes _____No _____

Have your children moved with or to join the worker above in the past 36 months?
Yes _____ No _____

Office Use Only

Home School: _____

All Home Language Surveys are to be filed in the student's cumulative folder.

**See the reverse side of this form for additional information regarding student language information*

Parent Signature _____ **Date** _____

Purpose and Intent of the Home Language Survey

"The home language survey questions attempt to inform the district of the possible impact on a child's English language development due to transfer, influence, or exposure to a language other than English. It is not at all assumed that a child who has a language other than English is less proficient in English as a result of knowing another language.

The questions are not intended to identify children who are learning a language other than English by watching educational media that teach languages, words, or phrases other than English. The questions are also not intended to identify children who are studying a world language for the purpose of becoming bilingual or more knowledgeable about languages other than English. Examples may include taking a Saturday German class, or taking Spanish as a graduation requirement in high school, or being instructed informally by someone in the home who wishes to encourage a child to learn another language."

Kansas Department of Education, January 9, 2013

SHAWNEE MISSION
SCHOOL DISTRICT

STUDENT ENROLLMENT FORM

FOR OFFICE USE ONLY - SCHOOL INFORMATION START DATE _____

STUDENT NO_____ SCHOOL YEAR_____ SCHOOL NAME _____ HOME ROOM _____ GRADE_____

NEW ENROLLMENT ☐ RE-ENTRY ☐ LOCKER #_____

Please **PRINT** clearly in unshaded areas

STUDENT INFORMATION

LEGAL LAST NAME SUFFIX (JR II etc.)	FIRST NAME	MIDDLE NAME	COMMON NICKNAME

DATE OF BIRTH (MM/DD/YEAR)	GENDER (M/F)	BIRTH STATE (OR COUNTRY IF NOT UNITED STATES)

ETHNICITY (SELECT ONE)	RACE (CHECK ALL THAT APPLY)
☐ No, not Hispanic/Latino	☐ White ☐ Black/African American ☐ Asian
☐ Yes, Hispanic/Latino	☐ Native Hawaiian/other Pacific Islander ☐ American Indian/Alaskan Native

PRIMARY LANGUAGE SPOKEN : OTHER LANGUAGE SPOKEN AT HOME:

SCHOOL LAST ATTENDED _____ IS STUDENT CURRENTLY UNDER LONG-TERM SUSPENSION OR EXPULSION? ☐ YES ☐ NO

HAS STUDENT ATTENDED A SHAWNEE MISSION SCHOOL PREVIOUSLY? ☐ YES ☐ NO

PLEASE INDICATE IF STUDENT HAS AN I.E.P. ☐ YES ☐ NO PLEASE INDICATE IF STUDENT HAS A 504. ☐ YES ☐ NO

FAMILY INFORMATION

COURT ORDER REGARDING CUSTODY? ☐ YES ☐ NO (Non-custodial parent may have access to student information unless prohibited by court order. The school must have a copy of the legal documents if access is prohibited.)

DO YOU WISH TO RESTRICT STUDENT/FAMILY INFORMATION? ☐ YES ☐ NO (If you choose to restrict your student/family information, your student's name will not appear in the student directory and his/her name will not be provided to outside agencies including the U.S. military or colleges/universities.)

DOES STUDENT HAVE A PARENT ON ACTIVE DUTY IN THE U.S. MILITARY? ☐ YES ☐ NO

PRIMARY RESIDENCE CONTACT INFORMATION

HOME ADDRESS	CITY	STATE	ZIP

GUARDIAN 1 LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

EMAIL ADDRESS : **EMPLOYER:**

GUARDIAN 2 LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

EMAIL ADDRESS : **EMPLOYER:**

SECONDARY RESIDENCE CONTACT INFORMATION

HOME ADDRESS	CITY	STATE	ZIP

GUARDIAN 1 LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

SECONDARY RESIDENCE CONTACT INFORMATION, continued

GUARDIAN 2 LAST NAME | FIRST NAME | MIDDLE NAME | RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

EMAIL ADDRESS : **EMPLOYER:**

ADDITIONAL RESIDENCY INFORMATION

This section addresses the McKinney-Vento Act. Where is the student currently living? (check only one)

☐ In a shelter_____ (name shelter) ☐ In a motel, car, or campsite	☐ Alone without parental support(independent living student) ☐ **Temporarily** with more than one family (due to loss of job, housing etc.)	☐ **Temporarily** with more than one family in a house, mobile home, or apartment because the family doesn't have a place of their own. ☐ None of these apply

ALL CHILDREN RESIDING AT RESIDENCE

	LAST NAME	FIRST NAME	BIRTHDATE	SCHOOL
1.			__/__/___	
2.			__/__/___	
3.			__/__/___	
4.			__/__/___	

MIGRANT ELIGIBILITY

1. Have you or a member of your family moved in the last 36 months to do, or apply for, agriculture or fishing related work, including dairies, nurseries, meat or vegetable processing, feed yards, or field work? ☐ Yes ☐ No
2. Have your children moved with or to join the worker above in the past 36 months. ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION (In case of emergency or illness when parent cannot be reached)

#1 LAST NAME | FIRST NAME | TITLE | RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

#2 LAST NAME | FIRST NAME | TITLE | RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

#3 LAST NAME | FIRST NAME | TITLE | RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

I understand that knowingly providing false information on this form may result in criminal prosecution under Kansas Statute § 21-5824, which prohibits the making of false information with the intent to defraud or induce official action – a FELONY.

I will notify the school office immediately or within three (3) business days, if at any time this student moves from the primary residence listed above or changes address.

SIGNATURE_____ DATE_____

Date of Birth_____

SMSD
Health Services

Health History Form

Student's Name	Date of Birth / /	Age	Sex (M/F)	Grade

Mother/Guardian _____	Father/Guardian _____
Cell Phone: (____)____-____	Cell Phone: (____)____-____
Home Phone: (____)____-____	Home Phone: (____)____-____
Work Phone: (____)____-____	Work Phone: (____)____-____

Name of Physician _____ Phone (____)____-____

Name of last school attended _____ City/State _____

Special Healthcare Planning/Serious Health Conditions The school must be notified of a serious or life threatening health condition prior to the start of school as this may require an Individualized Health Plan.

☐ Allergy/Anaphylaxis: My child has severe allergy/anaphylaxis requiring an Epi Pen/Auvi-Q prescription.

Describe the allergy (food, insect, etc.) _____

☐ Asthma: ☐ Yes ☐ No My child uses rescue inhaler routinely for asthma symptoms

☐ Yes ☐ No My child has been hospitalized in the past year for asthma

☐ Yes ☐ No My child has needed steroids (prednisone) for asthma symptoms in the past year

☐ Diabetes: Date of diagnosis: _____ My student has: ☐ insulin pump ☐ insulin pen ☐ injected insulin

☐ Seizure Disorder: My student needs emergency medication for seizures. Name of medication: _____

☐ Other: My child has special health care needs: wheel chair, tube feedings, breathing tube, catheter, intravenous tubes, other. Please describe your child's condition and healthcare needs: _____

Other Health Conditions Check any condition your child currently has or has had in the past:

☐ ADD/ADHD	☐ Depression/Anxiety	☐ Orthopedic/Bone
☐ Allergies ☐ Seasonal	☐ Dental ☐ Braces/Orthodontia	☐ Serious Injury
☐ Dietary Restrictions	☐ Ear Infections ☐ Ear Tubes	☐ Surgery(s)
☐ Bladder/Bowel	☐ Hearing Impairment ☐ Hearing Aides	☐ Social/Emotional/Behavioral
☐ Blood Disorder	☐ Headaches/Migraines	☐ Stomach Aches
☐ Concussion	☐ Heart Disease	☐ Throat Infections
☐ Cancer	☐ Kidney Disease	☐ Vision: ☐Glasses ☐Contacts

Explain any health condition(s) checked _____

Does your child require any restriction of physical activity in school? ☐ No ☐ Yes, specify nature and duration of restriction:

_____

Emergency Contact (if parent/guardian cannot be reached)

1. Name _____ Relationship _____ Phone (____)____-____

2. Name _____ Relationship _____ Phone (____)____-____

Preferred Hospital _____ City/State _____

Statement of Consent *In order to better serve the healthcare needs of my child, I give my permission for the transfer of health information to the school and any other appropriate school or healthcare professionals including emergency personnel. This includes release of school immunization records to the KS Immunization Program, and the immunization registry for the purpose of assessment, reporting, and prevention of disease. I authorize school personnel to obtain emergency medical care for my student in the event I cannot be reached.*

Print Parent/Guardian Name	Signature of Parent/Guardian	Date / /

Revised 5/2015

SHAWNEE MISSION SCHOOL DISTRICT

Medication Permission Form

Student Name | Birthdate | Grade | School Year

Over-The-Counter Medication

By initialing below, I give permission for school personnel to administer the following medication(s) as needed to my student for minor discomfort or injury. Medications supplied by school may vary between buildings and grade levels.

_____ Acetaminophen (Tylenol)
_____ Ibuprofen (Advil or Motrin)
_____ Cough drop (non-medicated)
_____ Topical medication (antibiotic ointment, calamine lotion, hydrocortisone cream)
_____ Antacid (Tums)
_____ Eye drop (non-medicated lubricating)
_____ Antihistamine oral (diphenhydramine, cetirizine)
_____ Antihistamine allergy eye drops

Parents may also supply other over-the-counter medications. Please list below:

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

Prescription Medication

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

On early dismissal or late start days please indicate one of the following:

_____Do NOT administer medication on early dismissal days _____Administer medication at adjusted lunch time
_____Do NOT administer medication on late start days _____Administer medication at prescribed time

To ensure continuity of care, I give permission for the school nurse to communicate with my student's healthcare provider regarding medication administration at school.

Physician name: Phone number

Physician signature (required if no Rx label):

School personnel who administer medication according to proper dosing instructions shall be held harmless for any adverse reaction experienced by the student. My student has previously taken the medications(s) listed above with no known adverse reaction.

Parent/guardian printed name:

Parent/guardian signature: Date

SHAWNEE MISSION
SCHOOL DISTRICT

Medication Administration Guidelines

Permission: Written permission from the parent or guardian must be on file for all medications given at school, including over-the-counter (OTC) medications. Authorization must be renewed every school year.

Medication: Only FDA approved prescription and OTC medications are allowed to be administered by school personnel. OTC medications will be given per package label dosing instructions, unless prescribed by a physician.

Container: Prescription medication brought to school must be in the original container with a current prescription label on the bottle including the child's name, doctor's name, date, medication name, dosage, and time to be given. Controlled substances must be submitted with a Medication Count Form. OTC medications provided by parent must be in the original container and labeled with the student's name.