SHAWNEE MISSION SCHOOL DISTRICT

Oak Park-Carpenter Elementary School

ENROLLMENT PROCESS

Please carefully complete and return all forms. You may drop off completed forms at the school office, email them to monicaglenn@smsd.org or fax to 913-993-4199. Thank you!

- **Enrollment Form**
- **Home Language Survey**
- **Health Forms**
- **State issued Birth Certificate**
- **Proof of Residency– the district requires 2 forms of proof**
    - **<u>If you rent/lease your residence:</u>**
        - **A current copy of your lease showing all pertinent information such as address, your name and dates the lease covers. All residents must be listed on the agreement.**
        - **AND Two current utility bills in your name at the address listed. Gas, electric, water, and wastewater are all acceptable utilities. We cannot accept cable, credit card and/or cell phone bills.**
    - **<u>If you own your home:</u>**
        - **A copy of the sale contract for your residence if you have recently purchased your home, a mortgage statement or a copy of your real estate taxes. Your name and the address must be listed on the document. Financial information may be blacked out.**
        - **AND Two current utility bills in your name at the address listed. Gas, electric, water, and wastewater are all acceptable utilities. We cannot accept cable, credit card and/or cell phone bills.**

Sincerely,

Jennifer Morgan
Oak Park-Carpenter Principal

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_____

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 <u>not</u> 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** _____

Updated 06/28/2017

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

Immunization Statement

Name of Student _____

To: Principal/Nurse of _____

I, the parent/guardian of _____, state that all tests and/or inoculation required by Kansas School Immunization Laws 72-5208, 72-5209, as amended in 1992, are in the process of being received. Records indicating completion of all required immunizations according to Kansas Certificate of Immunization will be in the school nurse's office within sixty (60) days after enrollment to school.

All students enrolling in the Shawnee Mission School District for the first time, must show written proof that they have received at least one dose of each of the immunizations required by the state of Kansas before they may attend any classes.

I further understand that if I have not presented information showing immunizations are up to date within 60 days of enrollment, the student will be excluded from school until proof of required immunizations is provided.

Parent/Guardian Signature _____

Date Signed _____

KANSAS CERTIFICATE OF IMMUNIZATIONS (KCI)

This record is part of the student's permanent record and shall be transferred from one school to another as defined in Section 72-5209 (d) of the Kansas School Immunization Law (amended 1994.)

Student Name: _____ Address: _____

Parent or Guardian Name: _____

Phone: _____

Birthdate (MM/DD/YYYY): _____ SEX: [ ] MALE [ ] FEMALE Race: _____ Ethnicity: _____ County: _____

VACCINE	RECORD THE MONTH, DAY, AND YEAR THAT EACH DOSE OF VACCINE WAS RECEIVED = Dose determined invalid by provider = Invalid Dose. KSWebIZ minimum age/interval not met						
	1st	2nd	3rd	4th	5th	6th	7th
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis) Required for school entry. Single Tdap required for grades 7-12. State Type							
Polio Required for school entry.						If additional doses are added, please initial the dose and sign below:	
HEP B (Hepatitis B) Required for school entry.							
Varicella (Chickenpox) Required for school entry.			Hx of Disease: NO Date of Illness: _____ Physician Signature:				
MMR (Measles, Mumps, and Rubella combined) Required for school entry.							
Influenza (Flu) Recommended annually for ages 6mo and older. Not required for school entry.							
HIB (Haemophilus Influenzae Type B) Required < 5 years of age for preschool or child care operated by a school.							
PCV (Pneumococcal Conjugate) Required < 5 years of age for preschool or child care operated by a school.							
HEP A (Hepatitis A) Required < 5 years of age for preschool or child care operated by a school.							
MCV4 (Meningococcal) Initial dose recommended at 11-12 years of age and booster dose recommended after 16 years of age. Not required for school entry.							
HPV (Human Papillomavirus) Recommended for males and females at 11-12 years of age. Not required for school entry.							
Rotavirus Recommended < 8 mo. Not required for school entry.							

DOCUMENTATION

KCI MAY ONLY BE SIGNED BY A PHYSICIAN (MD/DO), HEALTH DEPT, OR SCHOOL.

☐ I certify I reviewed this student's vaccination record and transcribed it accurately

Agency Name:

Authorized Representative:

Address:

The record presented was: Date _____

☐ Kansas Immunization Record

☐ Other Immunization Record (Specify) _____

LEGAL ALTERNATIVES TO VACCINATION REQUIREMENTS "KSA 72-5209"

1. "Annual written statement signed by a licensed physician (Medical Doctor/M.D. or Doctor of Osteopathy/D.O.) stating the physical condition of the child to be such that the tests or inoculations would seriously endanger the life or health of the child." Medical exemption shall be validated annually by physician completion of KCI Form B and attachment to the KCI.

2. "Written statement signed by one parent or guardian that the child is an adherent of a religious denomination whose religious teachings are opposed to such tests or inoculations."

KANSAS IMMUNIZATION PROGRAM
1000 SW Jackson, Suite 210, Topeka, KS 66612-1274
PHONE 785-296-5591 FAX 785-296-6510

I give my consent for information contained on this form to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

_____ _____

Parent/Legal Guardian's Signature Date

Rev. 1/2017

SHAWNEE MISSION SCHOOL DISTRICT

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

PHYSICAL EXAMINATION STATEMENT

Name of Student _____

TO: Principal/Nurse of _____

I, the parent/guardian of _____, am affirming that I understand that the Kansas statute states that the above named student is required to have a physical examination within ninety (90) days after school enrollment or show proof that one has been conducted within 12 months prior to enrollment.

I further understand that if the results of a physical examination are not forwarded to the school nurse or principal by the date noted below, the student will be excluded from school.

Parent/Guardian Signature _____

Date _____

SHAWNEE MISSION
SCHOOL DISTRICT

Physical Exam Record

To be completed by certified healthcare professional

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

Does the child have a diagnosed medical condition? ☐ No ☐ Yes
Specify:

Does the child have a health condition that may require EMERGENCY ACTION while at school? ☐ No ☐ Yes
(e.g.: seizure, severe allergic reaction, diabetes)
Specify:

Is the child on prescription medication? ☐ No ☐ Yes
Specify medication and diagnosis:

Are any immunization, booster, or revaccinations indicated? ☐ No ☐ Yes
Specify type and due date:

Does the child have history of chicken pox disease? ☐ No ☐ Yes
Specify date:

Does the child require any restriction of physical activity in school? ☐ No ☐ Yes
Specify nature and duration of restriction:

EXAM FINDINGS/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area Of Concern	Yes	No	Referred for Evaluation
Head				Developmental			
Eyes				Mobility			
ENT				Speech/language			
Neuro				Hearing			
Dental				History of frequent ear infections			
Respiratory				Vision			
Cardiac				Nutrition			
GI/GU				History of traumatic head injury			
Abdomen				Signs of acanthosis nigricans			
Endocrine				Learning disability			
Skin				Attention deficit hyperactivity disorder (ADHD)			
Genital				Psychosocial			
Orthopedic				Other:			

Please explain any abnormal or area of concern findings:

SCREENING RESULTS

Height: ft. in.	Weight: lbs.	Body Mass Index (BMI):	
Blood Pressure:		Vision: L 20/ R 20/ Both 20/ Glasses ☐ Contacts ☐	
Print Name		**Signature of Healthcare Provider**	**Date** / /

State law (K.S.A. 72-5214) requires all children up to the age of nine entering a Kansas public school for the first time present results of a health assessment prior to school entry.

Revised 3/2017

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.

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

Revised 2/15/2017