



STUDENT ENROLLMENT FORM

FOR OFFICE USE ONLY - SCHOOL INFORMATION				START DATE _____	

STUDENT NO _____	SCHOOL YEAR _____	SCHOOL NAME _____	HOME ROOM _____	GRADE _____	
NEW ENROLLMENT <input type="checkbox"/>	RE-ENTRY <input type="checkbox"/>	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)	
<input type="checkbox"/> No, not Hispanic/Latino		<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian	
<input type="checkbox"/> Yes, Hispanic/Latino		<input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native	
PRIMARY LANGUAGE SPOKEN :		OTHER LANGUAGE SPOKEN AT HOME:	
SCHOOL LAST ATTENDED _____ IS STUDENT CURRENTLY UNDER LONG-TERM SUSPENSION OR EXPULSION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
HAS STUDENT ATTENDED A SHAWNEE MISSION SCHOOL PREVIOUSLY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PLEASE INDICATE IF STUDENT HAS AN I.E.P. <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE INDICATE IF STUDENT HAS A 504. <input type="checkbox"/> YES <input type="checkbox"/> 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 _____	
() _____ - _____		() _____ - _____	
<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER
EMAIL ADDRESS :		EMPLOYER:	
GUARDIAN 2 LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____ RELATIONSHIP TO STUDENT _____			
PRIMARY PHONE NUMBER _____		SECONDARY PHONE NUMBER _____	
() _____ - _____		() _____ - _____	
<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> 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 _____	
() _____ - _____		() _____ - _____	
<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> 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
() _____ - _____		() _____ - _____		() _____ - _____
<input type="checkbox"/> HOME	<input type="checkbox"/> WORK	<input type="checkbox"/> CELL	<input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER
EMAIL ADDRESS :			EMPLOYER:	

ADDITIONAL RESIDENCY INFORMATION

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

<input type="checkbox"/> In a shelter _____ (name shelter) <input type="checkbox"/> In a motel, car, or campsite	<input type="checkbox"/> Alone without parental support (independent living student) <input type="checkbox"/> Temporarily with more than one family (due to loss of job, housing etc.)	<input type="checkbox"/> Temporarily with more than one family in a house, mobile home, or apartment because the family doesn't have a place of their own. <input type="checkbox"/> None of these apply
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have your children moved with or to join the worker above in the past 36 months.	<input type="checkbox"/> Yes <input type="checkbox"/> 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
() _____ - _____		() _____ - _____		() _____ - _____
<input type="checkbox"/> HOME	<input type="checkbox"/> WORK	<input type="checkbox"/> CELL	<input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER
#2	LAST NAME	FIRST NAME	TITLE	RELATIONSHIP TO STUDENT
PRIMARY PHONE NUMBER		SECONDARY PHONE NUMBER		ADDITIONAL PHONE NUMBER
() _____ - _____		() _____ - _____		() _____ - _____
<input type="checkbox"/> HOME	<input type="checkbox"/> WORK	<input type="checkbox"/> CELL	<input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> OTHER
#3	LAST NAME	FIRST NAME	TITLE	RELATIONSHIP TO STUDENT
PRIMARY PHONE NUMBER		SECONDARY PHONE NUMBER		ADDITIONAL PHONE NUMBER
() _____ - _____		() _____ - _____		() _____ - _____
<input type="checkbox"/> HOME	<input type="checkbox"/> WORK	<input type="checkbox"/> CELL	<input type="checkbox"/> OTHER	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL <input type="checkbox"/> 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 _____



Upon enrollment, every student or parent/guardian must be given a Home Language Survey according to state and federal regulations. This survey will be used to determine which students should be assessed for English proficiency and to determine eligibility under the Migrant Education Program. If a language other than English is indicated in any of questions 1-4, the student will be assessed to determine eligibility for English to Speakers of Other Languages (ESOL) services. Knowledge of, or exposure to another language does not, in and of itself, qualify a student for ESOL services. Please complete one form for each child.

Student Information:

Name		Grade
Address		Date of Birth
First Date of Attendance in a U.S. School	US 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 means.
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 at home speak/use?
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:

5. In which languages do you read/write? English ___ Spanish ___ Other (specify) _____

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.

If an answer to either question 6 or 7 below is "yes," please fax this form to the ELL office at 913-993-8679. The migrant office will contact the family.

6. Has your family moved in the last 36 months to seek or obtain agriculture or fishing related work? Yes ___ No ___
7. If "yes," was the move from one school district to another? 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

KANSAS

Parent Consent for Release of Information and Medicaid Reimbursement

Consent to Release Information:

I consent for Shawnee Mission School District USD#512 (School) to release records or information about my child's participation in services to participating physicians, other health care providers, the Kansas Department of Health and Environment (KDHE), any KDHE billing agents, and any school billing agent, as necessary, to process claims for reimbursement by KDHE for covered health-related services, evaluations for these services and transportation, on the day the student receives any health-related service, which are outlined in the child's Individualized Education Program (IEP), including duration and frequency of IEP services.

Consent to Access Public Benefits

- I give consent for the school to access the child's or parent's public benefits or insurance to pay for services under 34 C.F.R. part 300.

Procedural Safeguards:

- I understand that the school may be required to provide certain health-related services to a student who has an IEP at no additional cost to the student's parent(s), and that my refusal to sign this form will not affect whether such services are provided at no cost to the student named above.
- I understand that I will not be required to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services. I understand that my child's Medicaid benefits will not be used if that use will:
 - (a) decrease available lifetime coverage or any other insured benefit;
 - (b) result in your family paying for services that would otherwise be covered by a public benefit or insurance program and that are required for the child outside of the time the child is in school;
 - (c) increase premiums or lead to the discontinuation of benefits of insurance; or
 - (d) risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.
- I also understand that the granting of consent is voluntary and may be withdrawn at any time. If I later revoke consent, that revocation is not retroactive (i.e. it does not negate any action that has occurred after the consent was given and before the consent was revoked).

I give consent for the school to release Education Records or information and to access Public Benefits as described above in order to submit claims to the Kansas Department of Health and Environment (KDHE),

Student ID #

I **do not** give consent.

Child's Name

Date of Birth

Parent/Guardian Signature

Date

Parent/Guardian Printed Name

Kids #:



Immunization Statement

Name of Student _____

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: _____

Physical Examination Statement

Name of Student _____

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 the 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: _____

Birth Certificate Statement

Name of Student _____

I, the parent/guardian of the student named above, am affirming that I understand the Shawnee Mission School District Board of Education Policy JBC,III. Proof of Identity, requiring a state certified copy of my child's birth certificate within thirty (30) days after school entry for any student entering a Shawnee Mission School.

I further understand that if the state certified copy of the birth certificate is not provided to the Early Childhood Education Center Office within the thirty day grace period, the student may be excluded from school and the proper authorities notified.

Parent/Guardian Signature: _____

Date: _____

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:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Orthopedic/Bone
<input type="checkbox"/> Allergies <input type="checkbox"/> Seasonal	<input type="checkbox"/> Dental <input type="checkbox"/> Braces/Orthodontia	<input type="checkbox"/> Serious Injury
<input type="checkbox"/> Dietary Restrictions	<input type="checkbox"/> Ear Infections <input type="checkbox"/> Ear Tubes	<input type="checkbox"/> Surgery(s)
<input type="checkbox"/> Bladder/Bowel	<input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Hearing Aides	<input type="checkbox"/> Social/Emotional/Behavioral
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Stomach Aches
<input type="checkbox"/> Concussion	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Throat Infections
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Vision: <input type="checkbox"/> Glasses <input type="checkbox"/> 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 / /
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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
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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 <input type="checkbox"/> Contacts <input type="checkbox"/>
Print Name	Signature of Healthcare Provider	Date / /



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.