

SOUTHERN LYON COUNTY USD #252

PARENTS MUST COMPLETE ENTIRE FORM IN FULL FOR EACH STUDENT

-----Student Household Information-----

Enrolling in: Hartford Jr/Sr High, Neosho Rapids Elementary, Olpe Elementary, Olpe Jr/Sr High

Date Enrolled: _____ District student currently resides _____ Grade at Entrance: _____

Student **Full Legal** Name (as shown on Birth Certificate)

(Last Name)

(First Name)

(Middle Name)

(Suffix, e.g. Jr. II)

Nickname to be used at school _____ Gender: Male Female Birth Date _____ S.S.# _____

Student Lives With:

- Both Parents Mother Only Father Only Legal Guardian
 Each Parent Alternately (please fill out secondary address form) Parent & Step Parent Foster Parents

Student Resident Address:

(Number)

(Street)

(Apt/Lot)

(City)

(Zip Code)

(County)

Mailing Address: (only if different from resident address)

(P.O. Box)

(City)

(Zip)

Race and Ethnicity: (Note: both Part A and Part B of the question **must be answered.**)

Part A: **Is this student Hispanic/Latino?** (Choose only one)

- No, Not Hispanic/Latino**
 Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

The above part of the question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate what you consider your student's race to be.

Part B: **What is the student's race?** (Choose one or more)

- American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)
 Asian (A person having origins in any of the original peoples of the Far East, southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.)
 Black or African American (A person having origins in any of the black racial groups of Africa.)
 Native Hawaiian or other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
 White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Important Questions (Please answer the following questions)

1. Will the student be bused to and from school? Yes No
2. Is either parent/guardian a migratory agricultural worker, dairy worker or a fisher? Yes No
3. Does your student speak or understand English? Yes No
4. Has a language other than English been commonly spoken in the student's home? Yes No
If yes, what languages are spoken in the home? _____
5. Does your student have an active Individual Education Plan (IEP)? Yes No
6. Is your student in any other special help programs? (e.g. special reading, reading recovery)? Yes No
If yes, please list _____

I attest that the information contained here in is correct to the best of my knowledge.

Legal Parent /Guardian Signature _____ Date _____

-----Primary Household Information-----

This form only needs to be filled out one time per household unless information is different per child.

Please list All Children in household and their birth dates:

1. _____ birth date _____ 4. _____ birth date _____
 2. _____ birth date _____ 5. _____ birth date _____
 3. _____ birth date _____ 6. _____ birth date _____

Note: If a parent/guardian lives in a secondary household (separate home), please fill out Secondary Household form.

Father **Guardian-Relationship** _____ Father is: Single Married Deceased

 (Last Name) (First Name) (Middle Name) (Suffix, e.g. Jr. II)

Cell Phone _____ Other Phone _____ Pager _____

Name of Employer _____ Work Phone _____ Ext. _____ Email _____

Mother **Guardian-Relationship** _____ Mother is: Single Married Deceased

 (Last Name) (First Name) (Middle Name) (Suffix, e.g. Jr. II)

Cell Phone _____ Other Phone _____ Pager _____

Name of Employer _____ Work Phone _____ Ext. _____ Email _____

*******Emergency Contacts OTHER than Parent*******

1. This individual is a valid contact for:

a. All students in my household
 b. Only for _____ who's in _____ attending _____
 (Student) (Grade) (Building)

1. Emergency Contact Name:
 _____ Gender: **M F** *Allowed to pick child up from school: **Y N**
 (First Name) (Last Name) (Relationship to Student)

Home Phone _____ Cell Phone _____ Address: _____
 (Number) (Street) (City)

2. This individual is a valid contact for:

a. All students in my household
 b. Only for _____ who's in _____ attending _____
 (Student) (Grade) (Building)

1. Emergency Contact Name:
 _____ Gender: **M F** *Allowed to pick child up from school: **Y N**
 (First Name) (Last Name) (Relationship to Student)

Home Phone _____ Cell Phone _____ Address: _____
 (Number) (Street) (City)

3. This individual is a valid contact for:

a. All students in my household
 b. Only for _____ who's in _____ attending _____
 (Student) (Grade) (Building)

1. Emergency Contact Name:
 _____ Gender: **M F** *Allowed to pick child up from school: **Y N**
 (First Name) (Last Name) (Relationship to Student)

Home Phone _____ Cell Phone _____ Address: _____
 (Number) (Street) (City)

SOUTHERN LYON COUNTY U S D #252

PARENTS MUST COMPLETE ENTIRE FORM IN FULL FOR EACH STUDENT

Medical Release Form (To be carried by Sponsor)

Hartford Jr/Sr High,
620-392-5515

Neosho Rapids Elementary,
620-342-7783

Olpe Elementary,
620-475-3277

Olpe Jr/Sr High
620-475-3223

Student Legal Name _____ Date of Birth _____ Grade _____

Parent/Guardian Name _____ Home Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

-----**Emergency Contact other than Parent**-----

Contact Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Physician _____ Office Phone _____ Office Address _____

Dentist _____ Office Phone _____ Office Address _____

Name of Insurance _____ Policy Number _____

Does your student have difficulty breathing after exercise? _____ Has your student been diagnosed with Asthma? _____

If yes, does he/she use an inhaler? _____ What medication is in your student's inhaler? _____

When was student's last tetanus shot? _____ Does your student wear glasses? _____ Contacts? _____

Please list any allergies your student has to :

Medications _____ Food _____

Other(stings, pollen, etc _____

Any other health problems or concerns with your student? _____

I, _____, the parent or legal guardian of _____, give my consent for my child to participate in **any school sponsored activity**. I further give my legal consent and authorize any representative of Southern Lyon County USD 252 to authorize emergency medical treatment, including any necessary surgery or hospitalization, for my above named child, for any injury or illness of an emergency nature he/she incurred while participating in the activity noted above by any physician or dentist licensed in accordance with the provisions of the Kansas Healing Arts act, K.S.A. 65-2801 and any hospital.

I agree to pay and assume all responsibility for medical and hospital expenses and any emergency service incurred on behalf of my child.

I acknowledge and agree that Southern Lyon County USD 252 is not responsible for any medical, hospital expenses and/or charges that are incurred in the medical treatment or hospitalization of my child. A photo copy of this document shall have the same force and effect as the original. If my child requires emergency medical treatment, I understand that school personnel will make a reasonable attempt to contact me to seek my permission to authorize treatment. To facilitate contacting me, I agree to provide current work and home phone numbers to the school.

Parent or Legal Guardian signature _____ Date _____

-----Student Medical History-----

Please provide the school with an up to date copy of your student's Immunization record.

Optometrist Name _____ Office Phone _____ Office Address _____

Hospital Preference _____

Please list and date any surgeries or serious illnesses you student has had in the past. _____

Has your student ever had a head injury? _____ History of Concussions or been knocked unconscious? _____

If so, please explain. _____

Does your student have any physical problems or handicaps? _____

Does your student take prescription medications on a routine basis? (Daily) _____

Please list the NAMES and DOSAGES of medications your student takes. Please include Vitamins and Supplements. Also include any over the counter drugs taken on a routine basis. (Tylenol, Motrin, Benadryl, etc.)

1. _____ 2. _____

3. _____ 4. _____

Has your student been diagnosed with ADD? _____ Has your student been diagnosed with ADHD? _____

Females:

Has your daughter begun menstruation? _____

Is she experiencing problems with irregularity, increased flow, pain, or cramping? _____

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

Parent/Legal Guardian's Signature

Date