Jefferson Elementary School
2016-2017 Student Enrollment Packet

Student Full Name	Grade Level	Teacher
_____	_____	_____

Hello Prospective Parents and Guardians:

Thank you for your interest in enrolling your child at Jefferson Elementary School for the 2016 - 2017 academic school year. We are honored that you have chosen our school.

Jefferson Elementary School strives to help every student reach his or her potential while increasing academic achievement. We accomplish this with our unique combination of research-based curriculum, certified teachers, and integrated technology. We look forward to being the school of choice for your family.

Please complete the attached enrollment packet and return with the following documents:

- ☐ Birth Certificates — Received on: _____

  (Kindergarten students must be 5 years old by 7/31/10)
- ☐ Immunization Records — Received on: _____
- ☐ Student's Most Recent Report Card — Received on: _____
- ☐ Proof of Residency *(Lease, Utility Bill, etc.)* — Received on: _____
- ☐ Parent/Guardian Photo ID — Received on: _____
- ☐ Student's Social Security Card — Received on: _____

Student Information

Student's Full Name: _____ **Grade Level:** _____

Present Age: _____ **DOB:** _____ **Gender:** ☐ M ☐ F

Parent 1 Full Name: _____ Relationship: _____

Parent 2 Full Name: _____ Relationship: _____

Guardian Full Name: _____ Relationship: _____

Home Address:

_____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Last school/day care attended? _____

Does student use a language other than English? ☐ Yes or ☐ No

Please specify:

Is a language other than English used at student's home? ☐ Yes or ☐ No

Please specify:

Has student ever received special education services? ☐ Yes or ☐ No

Please specify:

Is student currently in Missouri Children's Division(DFS) custody, or residing in a foster home/residential facility? ☐ Yes or ☐ No

Caseworker name: TEL #_____ _____ - _____

Presently, where is student living? ***Please check only one box.***

☐ In permanent, stable housing with parent(s) ☐ In a shelter
☐ In a motel, car, campsite, or temporary housing
☐ With more than one family in a house or apartment
☐ With friends or family members (other than parent/guardian)

Missouri Safe Schools Act Disciplinary Information: *(Providing false disciplinary information is a Class B misdemeanor.)*

Is student presently under suspension or expulsion from another school or district for violating school board policies relating to weapons, alcohol, drugs, willful infliction of injury to another person?

☐ Yes or ☐ No

If 'Yes," please describe:

Has student been charged or convicted of any felonies?

☐ Yes or ☐ No

If 'Yes," please describe:

PARENTS/GUARDIANS PLEASE READ.

By signing below I understand I *must personally* provide residence verification, immunization records, and birth records to my child's assigned school to complete my child's registration, and failure to present the required documents and paperwork will result in denial of enrollment.

X_____ _____
Parent Signature **Date**

X_____ _____
Parent Signature **Date**

Parent/Guardian Information

_____ _____

Student Full Name Grade Level

Parent's Status: ☐ Married ☐ Domestic Partners ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

First Parent's Name: _____

What does your child call this parent? _____

Home Address (*if different*): _____

Gender: ☐ M ☐ F

Home Phone: _____ Cell Phone: _____

Name of Employer: _____

Address of Employer: _____

Occupation/Position: _____ Work Phone Number: _____

Second Parent's Name: _____

What does your child call this parent? _____

Home Address (*if different*): _____

Gender: ☐ M ☐ F

Home Phone: _____ Cell Phone: _____

Name of Employer: _____

Address of Employer: _____

Occupation/Position: _____ Work Phone Number: _____

Transportation Information

_____ _____

Student Full Name Grade Level

Dear Parent or Guardian,

Please complete the below form with alternate site information, changes of address and telephone numbers for your child/children so that we may update our files to provide accurate information scheduling your child's transportation needs.

Please Fill/Check the Appropriate Information Below:

☐ My student walks to a residence. Address: _____

☐ My student rides the bus. Bus #: _____

☐ My student is picked up from school.

The following adults are authorized to pick or drop off my child.

_____ _____

Full Name Contact Phone

_____ _____

Full Name Contact Phone

_____ _____

Full Name Contact Phone

☐ My student rides a daycare/afterschool van.

Daycare/Program _____ Effective Date_____

Address_____

Telephone Number_____ Cell Number_____

Student Health Information

_____ _____

Student Full Name Grade Level

Does your child have any health problems or allergies?

_____

_____

_____

_____

_____

_____

_____

_____

Has your child been immunized? ☐ **Yes** ☐ **No**

Is your child under any medical insurance plan? ☐ **Yes** ☐ **No**

What is the medical carrier name? _____

Type of Plan: ☐ **PPO** ☐ **HMO** ☐ **POS** ☐ **Other:** _____

Who is the primary subscriber (name) of the plan? _____

Emergency Contact Information

Student Full Name _____ Grade Level _____

PRIMARY PHYSICIAN:

Name _____ Contact Phone _____

DENTIST:

Name _____ Contact Phone _____

HOSPITAL PREFERENCE:

Name _____ Insurance Plan _____ Member # _____

In the event of an emergency, I authorize the following adults to be contacted if I cannot be reached.

Full Name _____ Contact Phone _____ Relationship _____

Full Name _____ Contact Phone _____ Relationship _____

Full Name _____ Contact Phone _____ Relationship _____

I understand that in the event of serious accident or illness to the above named child requiring immediate attention every effort will be made to contact the adults listed above. If none of the above persons can be contacted, 1 hereby authorize school personnel to seek whatever medical attention is deemed necessary where it is available. ! authorize the attending physician and/or . other medically trained personnel to render necessary emergency treatment. 1 also agree to pay all expenses incurred for services rendered to the above named child.

Otherwise, I expect to be notified of serious accident or illness at once to the above named child and will make my own arrangements for medical care for my child.

X_____ _____

Parent Signature **Date**

St. Louis Public Schools Media Release Form

I understand the photograph(s) or video or audio recording (s) taken of my child by agents, employees or representatives of the St. Louis Public Schools (hereinafter called "SLPS") shall be used in connection with the SLPS's dissemination of information by its public service and academic programs to the general public.

I hereby irrevocably authorize the SLPS to copy, exhibit, publish or distribute any and all such images and audio of my child or wherein he/she shall appear, including composite or artistic forms and media, for purposes of publicizing SLPS programs or for any other lawful purpose. In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my child's likeness appears.

I hereby hold harmless and release and forever discharge the SLPS from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my or my child's behalf, may have by reason of this authorization.

_____ _____

Child's Legal Name (print clearly) **Birth Date**

I hereby certify that I am the parent or guardian of the minor named above and do hereby give my consent without reservations to the abovementioned.

_____ _____

Signature of Parent/Guardian **Date**

_____

Print Name of Parent/Guardian Name (print clearly)

Uniform Dress Code

Student Full Name _____ Grade Level _____

Top:	Light Blue, Dark Blue, or White Polo
Sweater:	Navy Blue Cardigan/Pullover/Vest Styles
Bottoms:	Navy Blue/Khaki Pants; Shorts, Skorts, or Jumpers

T-shirts are not acceptable outerwear as a part of the uniform dress code.

UNIFORM ENFORCEMENT WILL BEGIN ON THE FIRST DAY OF SCHOOL

Please Note: All children are required to wear tennis shoes with their uniform during Physical Education classes. Anyone wearing a skirt or dress must have a pair of shorts underneath the skirt or dress.

Signature of Parent or Guardian _____ **Date** _____

Student Health Registration Form / *RETURN TO SCHOOL NURSE*

This questionnaire is designed to aid the school nurse in anticipating any health concerns that might affect your child's safety or learning.

Student Name _____ Grade ____ Sex ____ Date of Birth _____
LAST FIRST MI

MEDICAL

Does your child have a doctor or nurse practitioner? Yes ___ No ___
Name of child's doctor or nurse practitioner _____ Phone # _____
In the past 12 months, did you have problems obtaining medical care for your child? Yes ___ No ___

DENTAL

Does your child have a dentist? Yes ___ No ___
Name of child's dentist _____ Phone # _____
Did your child receive a dental exam in the last 12 months? Yes ___ No ___
Describe the condition of your child's teeth? Good ___ Fair ___ Poor ___
In the past 12 months, did you have problems obtaining dental care for your child? Yes ___ No ___

INSURANCE

Does your child have medical insurance coverage? Yes ___ No ___ Name of Provider _____
Does your child have dental insurance coverage? Yes ___ No ___ Name of Provider
Does Medicaid (MO HealthNet) insure your child? Yes ___ No ___

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has:

___Asthma ___Seizure disorder ___Bleeding disorder ___ADD/ADHD
___Diabetes ___Bone/muscle disease ___Skin condition ___Learning disability
___Heart condition ___Mental health condition (i.e. depression, anxiety, eating disorder) ___Other_____

Does your child experience any of the following?

___Nose bleeds ___Frequent ear aches ___Overweight for age ___Physical disability
___Poor appetite ___Frequent stomachaches ___Frequent headaches ___Fainting spells
___Tires easily ___Emotional concerns ___Underweight for age ___Other _____

Do any of the condition(s) limit/effect your child at school? _____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes*___ No ___ Describe: _____

ALLERGIES

___Plants ___Animals ___Food ___Molds ___Drugs ___Bees ___ Other _____
Please describe the allergic reaction and the treatment for each checked allergy_____
_____
Do you plan for your child to receive school prepared meals? Yes___ No___
Will your child require food substitutions? Yes**___ No___

****The Medical Statement for Student Requiring Special Meals must be completed to allow food substitutions.**

MEDICATION

Does your child take any medication? Yes ___ No ___ If yes, name of medication(s) _____
Purpose_____ Will medication be needed at school? Yes*___ No___

If the answer to any of these questions is yes, please call to schedule a time to meet with the school nurse!

HEARING/VISION

Do you have concerns about your child's hearing? Yes___ No___ Does your child wear hearing aids? Yes___ No___
Do you have concerns about your child's vision? Yes___ No___ Does your child wear glasses or contacts? Yes___ No___

SPEECH/LANGUAGE

Do you have concerns about your child's speech and/or language? Yes___ No___
Do others have difficulty understanding your child? Yes___ No___ If yes, please explain_____
_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature _____ Date _____

Food Allergy Assessment Form

Student Name _____ DOB _____ Sex ___

Parent/Guardian _____ Home Ph _____ Cell Ph _____

Health Care Provider (name) treating food allergy _____ Phone _____

Do **you think** your student's food allergy may be **life-threatening?** ❑ No ❑ Yes

(If Yes, please see the school nurse as soon as possible.)

Did your student's **health care provider** tell you the food allergy may be **life-threatening?** ❑ No ❑ Yes

(If Yes, please see the school nurse as soon as possible.)

History and Current Status

Check the foods that have caused an allergic reaction:

- ❑ Peanuts
- ❑ Peanut or nut butter
- ❑ Peanut or nut oils
- ❑ Tree nuts (walnuts, almonds, pecans, etc.)
- ❑ Fish/shellfish
- ❑ Soy products
- ❑ Eggs
- ❑ Milk

Please list any others _____

How many times has your student had a reaction? ❑ Never ❑ Once ❑ More than once, explain

When was the last reaction?

Are the food allergy reactions: ❑ staying the same ❑ getting worse ❑ getting better

Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? *(Check all that apply)*

❑ Eating foods ❑ Touching foods ❑ Smelling/Inhaling foods ❑ Other, please explain _____

_____

What are the signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)* _____

_____

How quickly do the signs and symptoms appear after exposure to the food(s)?

_____ Seconds _____ Minutes _____ Hours _____ Days

Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

❑ No ❑ Yes, explain _____

_____

Does your student understand how to avoid foods that cause allergic reactions? ❑ Yes ❑ No

What treatment or medication has your health care provider recommended for use in an allergic reaction?

_____

_____

_____

HIPAA-Compliant Authorization for Release of Health Information

Student Name _____ **Date of Birth** _____

I hereby authorize _____ to release
Primary Care Provider, Address, And Phone
my/my child's health information/records for the purpose listed below to:

School Nurse _____ Phone _____

School _____ Grade _____ Room # _____

Address _____

Description:
The information to be disclosed consists of:

_____

_____

_____

Purpose:
This information will be used for the following purpose(s):

- ☐ Educational evaluation and program planning.
- ☐ Health assessment and planning for health care services and treatment in school.
- ☐ Medical evaluation and treatment.
- ☐ Other _____

Authorization

This authorization is valid for one calendar year. It will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____
Parent Signature Date

_____
Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Missouri, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for STD-HIV/AIDS, reproductive health care services, and general medical care.

Student name: _____ **Grade:** _____

PARENT PERMISSION FOR THE ADMINSITRATION OF OVER-THE- COUNTER MEDICATION

Listed below are nonprescription medications that the nurses can give to students only with parent permission. We hope that using these medications, as needed, will reduce both absenteeism and student discomfort while in school. If a student needs routine medications, other arrangements should be made. Medications will be given in age/weight appropriate doses. You will be informed if nonprescription medications are given to your child.

- Abreva or Carmex topical for cold sores or lesions on face or lips
- Acetaminophen (Tylenol) for headache and fever
- Albuterol (see Albuterol order) for emergency use in asthmatic reaction
- Benadryl (Diphenhydramine HCL) for allergy symptoms
- Benzocaine Sting Wipes for insect bites and stings
- Blistex (or generic) - for relief of chapped lips
- Calamine or Caladryl Lotion (or generic) for itchy rash (not to be applied around the eyes)
- Cepacol or other sore throat spray
- Chloriseptic throat spray or Listerine mouthwash for relief of sore throat
- Clotrimazole as an anti-fungal for skin itch and rash
- Contact Lens Solution for cleansing prescription and non-prescription contact lenses
- Cough Syrup (non-alcohol based, such as Robitussin) for dry coughs
- Epipen for emergency use in allergic shock
- Ibuprofen (Advil, Motrin) for muscle aches and pains, cramps, sinus pain
- Loratadiae (Claritin) for allergies and sinus
- Maalox (or comparable nonprescription antacid) in liquid or tablet form for stomach upset
- Natural tears (or any saline eye drops) for eye dryness and/or itching
- Ocean Nose Spray (or generic saline nasal spray) for stuffy nose or nasal dryness
- Oragel (or generic equivalent) for temporary relief of toothache
- Tolnafatate or Clotrimazole as an antifungal for skin itch and rash
- Topical antibiotic or vitamin (A&D) ointment for minor cuts and scrapes
- Topical Hydrocortisone Cream for minor skin irritation, minor bums, and rashes (not to be used on the face)
- Vicks Vapor Rub for congestion. Apply to chest only (not to be used on the face) *
- Visine Allergy Eye Drops for itching eyes

If you do not want a certain medication given to your child, cross out the name of the medication on the list above. No nonprescription medications will be given to students whose parents do not complete and return this form.

As the parent or legal guardian of the above named child, I give permission for the school nurses/nurse practitioner/physician associated with the School district to give the above named nonprescription medications to my child for the conditions indicated (except for any that I have crossed out.

_____ _____

Signature of Parent or Guardian **Date**