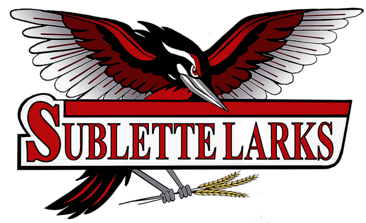
Please Do Not Staple

Student Information Form



STUDENT

Grade | ☐ Female ☐ Male | Birth Date

Last Name | First Name | Middle Name

Elementary Only Proof of Age Provided (*CHECK ONE*) ☐ Birth Certificate ☐ Hospital Record ☐ Transcript ☐ Other:

Is the student Hispanic/Latino? ☐ YES ☐ NO

Do any of the following apply to the student? ☐ 504 Plan—Disabilty accomodations not covered by Special Ed ☐ Special Ed Services ESOL / ELL Services

What is the student's race? (**Please select one or more)**

☐ American Indian OR Alaskan Native ☐ Asian ☐ Black OR African American ☐ Native Hawaiian OR Other Pacific Islander ☐ White

Student Physical Address		**Student Mailing Address** *(IF DIFFERENT FROM PHYSICAL ADDRESS)*	
	APT #		APT #
CITY, STATE	ZIP CODE	CITY, STATE	ZIP CODE

Student Cellphone Number

PARENT / GUARDIAN #1

LIVES WITH STUDENT ☐ YES ☐ NO	LAST NAME	FIRST NAME	MIDDLE NAME
RELATIONSHIP TO STUDENT	Mailing Address (if different from Student)	CITY, STATE	ZIP CODE

CHECK ALL THAT APPLY:

CONTACT ALLOWED? ☐YES ☐NO HAS CUSTODY ? ☐YES ☐NO If NO to Custody, Are MAILINGS ALLOWED? ☐YES ☐NO RELEASE TO ? ☐YES ☐NO

PRIMARY LANGUAGE	SPEAKS ENGLISH? ☐YES ☐NO	PARENT/GUARDIAN EMAIL	PLACE OF EMPLOYMENT

PRIMARY PHONE Number : ☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT ☐ UNLISTED

ALTERNATE PHONE Number : ☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT ☐ UNLISTED

PARENT / GUARDIAN #2

LIVES WITH STUDENT ☐ YES ☐ NO	LAST NAME	FIRST NAME	MIDDLE NAME
RELATIONSHIP TO STUDENT	Mailing Address (if different from Student)	CITY, STATE	ZIP CODE

CHECK ALL THAT APPLY:

CONTACT ALLOWED? ☐YES ☐NO HAS CUSTODY ? ☐YES ☐NO If NO to Custody, Are MAILINGS ALLOWED? ☐YES ☐NO RELEASE TO ? ☐YES ☐NO

PRIMARY LANGUAGE	SPEAKS ENGLISH? ☐YES ☐NO	PARENT/GUARDIAN EMAIL	PLACE OF EMPLOYMENT

PRIMARY PHONE Number: ☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT ☐ UNLISTED

ALTERNATE PHONE Number: ☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT ☐ UNLISTED

STUDENT NAME

EMERGENCY CONTACTS

1	RELATIONSHIP	NAME
PRIMARY PHONE : ☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT		ALTERNATE PHONE : ☐ CELL ☐ HOME ☐ WORK ☐ OK TOCONTACT
2	RELATIONSHIP	NAME
PRIMARY PHONE : ☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT		ALTERNATE PHONE : ☐ CELL ☐ HOME ☐ WORK ☐ OK TOCONTACT
3	RELATIONSHIP	NAME
PRIMARY PHONE : ☐ CELL ☐ HOME ☐ WORK ☐ OK TO CONTACT		ALTERNATE PHONE : ☐ CELL ☐ HOME ☐ WORK ☐ OK TOCONTACT

MEDICAL INFORMATION – THE SCHOOL CANNOT BE FINANCIALLY RESPONSIBLE FOR MEDICAL, DENTAL, AMBULANCE, OR HOSPITAL SERVICE.

PHYSICIAN'S NAME & Number	PREFERRED HOSPITAL	MEDICAID # (*IF APPLICABLE*)
Insurance Name / Group # / ID #		
ALLERGIES / HEALTH FACTORS / COMMENTS		LIFE THREATENING? ☐ YES ☐ NO

Please read and select Yes or No for each of the following.

☐ **YES** **NO** In the event of serious injury, it may be necessary to contact local emergency medical personnel immediately. Attempts will then be made to contact the parents/guardians or designated persons to inform them of the situation. The child will be treated by medical personnel as needed.

☐ **YES** **NO** In case of an illness or injury to the above named student, the school is authorized to proceed in its emergency medical plan including any necessary transportation to receive such treatment. I understand that the school is not financially responsible for individual medical, dental, ambulance, or hospital services. I realize that it will be necessary for me to inform the school of any address or phone number changes that may occur during the school year. I understand that the coaches/sponsors of my child will be prepared to take the appropriate emergency steps by keeping a copy of this form with them at all contests and activities.

☐ **YES** **NO** I give permission for the exchange of information between the school nurse or other school representative to copy and send this student's immunization records to schools, physician's offices, and health departments as needed.

☐ **YES** **NO** I give permission to USD #374 or its designated representative to permit my child's picture to be taken or likeness reproduced and disseminated to various media/communications, such as local newspapers and the district's website. I hereby release the above party from liabilities arising out of what I might deem misrepresentations by virtue of distortion, optical illusions or faulty mechanical reproductions. The publicity of that minor child received by virtue of the first such use that may be made thereof shall be full and adequate compensation for this consent. I agree all such uses of his/her name, voice, likeness, portraits, pictures, photographs, films videotapes, audiotapes, or writings and reproductions thereof, including but limited to tapes, plates, and negatives connected therewith are and shall remain property of USD #374.

Middle/High School ONLY

YES **NO** My child has permission to leave campus for school sponsored events during the school year.

PARENT/GUARDIAN SIGNATURE ______________________________ **DATE** ______________

Student Health Information Form

Last Name **First Name** **Grade**

Date of Birth **Emergency Contact Numbers**

Please check any medical conditions your student has:

- ☐ ADHD/ADD
- ☐ Asthma
- ☐ Birth Defects
- ☐ Hearing Difficulties
- ☐ Skin Problems
- ☐ Ear Infections
- ☐ Depression
- ☐ Diabetes
- ☐ Headaches
- ☐ Bone/Joint problems
- ☐ Anxiety
- ☐ Vision Difficulties
- ☐ Heart Defects
- ☐ Urinating Problems
- ☐ Serious Injury
- ☐ Seizures
- ☐ Stomach Problems
- ☐ High Blood Pressure
- ☐ Surgical History
- ☐ Anemia
- ☐ Constipation
- ☐ Other

Please explain checked medical conditions or anything more about your student's health that you think is important for us to know:

____

____

____

____

____

____

Allergies (Drug & Food) & Reaction:

1. ______________________________
2. ______________________________
3. ______________________________

Home Medications / Vitamins:

1. ______________________________
2. ______________________________
3. ______________________________

Assistive Devices: (glasses, contacts, braces, hearing aids etc)

1. ______________________________
2. ______________________________
3. ______________________________

Sublette School District
Transportation 2018-2019

PLEASE PRINT CLEARLY

Family's Last Name: ____________________

1st Child's Name	Grade	2nd Child's Name	Grade
3rd Child's Name	Grade	4th Child's Name	Grade
5th Child's Name	Grade	6th Child's Name	Grade

Do you live in town or in the country? Town: ☐ Country: ☐

Will your child(ren) ride the bus? Yes: ☐ No: ☐

If you live in the country what is your physical address:

____

Directions to your home from Sublette:

____

____

____

Phone Numbers

	Home Phone	Cell Phone	Work Phone
Mother's Name:			
Father's Name:			
Nearest Neighbors:	**Home Phone**	**Cell Phone**	**Work Phone**

If no one is at home when we arrive to drop off your child(ren) after school, what do you want the driver to do?

☐ Drop your child(ren) off anyway.
☐ Take my child(ren) back to the school.

Mud Routes

Some parents elect to have their child(ren) walk home from their mud route stop. Do you want us to allow your child to:

☐ Walk home from the mud stop.
☐ Take my child(ren) back to the school.

____________________ Parent Signature ____________________ Date

KAN Be Healthy (EPSDT) Screening Form

I.D. Number:______________________________

Please note the Mandatory Blood Lead Questionnaire is a separate document. It is required at each screen 6 to 72 months

Name	Date of Birth	Age	Date of Screen

PHYSICAL GROWTH

T ________ **Weight** __________ (lbs/kg) ________ th% **Weight/Length** ________ %

P ________ **Length** (Birth to 24 months) ________cm/in **Standing Height** (2 - 20 years) ________ cm/in

R ________ **BMI** __________ ________ th%

BMI ≥ 85%: recommend appropriate nutrition input and physical activity.

BP ________ Update Growth Chart (required at each screen)

Male ☐
Female ☐

Head Circ (≤ 24 months) ________ cm/in ________ th%

BENEFICIARY & FAMILY HISTORY

☐ Refer to completed history form in chart.
☐ No changes in medical Hx unless indicated.
☐ Previous Hx reviewed from_______________ visit.
☐ Patient currently in Foster care, no previous hx available.

Present Concern: ____________________

Medications: ____________________

Serious Illness/Accidents: ☐ No ☐Yes (date & type)
(including Hospital or ER visits)

Allergies (food & drug) ____________________

Birth History (Length, weight, complications, etc. - if known)

Operations: ☐ No ☐Yes (date & type)

(Circle and indicate the relationship with disease / problem. **P**-Parent, **G**-Grandparent, **B**-Brother, **S**-Sister, **Self**)

Allergies (food & drug)	________	Drug or ETOH Abuse	________	Mental Illness	________
Asthma	________	Earaches	________	Obesity	________
Birth defects	________	Epilepsy/Seizures	________	Scoliosis/Arthritis	________
Blood Disorder/ Sickle Cell	________	Headache	________	Speech, Visual, Hearing	________
Cancer	________	High Blood Pressure	________	Ulcers/Colitis	________
Colds/sore throat	________	Kidney/Liver Disease	________	Urinary/Bowel	________
Diabetes	________	Lung Disease	________	Heart Disease/Stroke	________

BODY SYSTEMS

SYSTEMS	WNL	ABN	Comments (Describe any Abnormal Findings)
General Appearance	☐	☐	
Integumentary	☐	☐	
Head-Neck	☐	☐	
Eyes/Ears/Nose & Throat	☐	☐	
Oral/Dental	☐	☐	
Pulmonary	☐	☐	Lung sounds?
Cardiovascular	☐	☐	Murmur?
Abdomen/Gastrointestinal	☐	☐	
Genitourinary	☐	☐	Tanner Score (as appropriate): Evaluate for excessive menstrual bleeding Enuresis
Trunk / Spine	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	

Vision Screen

Ages 0 to 3 yr - Corneal Light Reflex Present: Yes ☐ No ☐
Ages 3 yr thru 20 - Bruckner Exam: Pass ☐ Refer ☐
All ages - Outer Inspection: Normal ☐ Abnormal ☐
Eye Tracking: Pass ☐ Refer ☐ PERRLA: Pass ☐ Refer ☐
Ocular Motility(strabismus/cross cover test):Pass ☐ Refer ☐

Ages 3 thru 20:
.Distance Acuity - Tool used:__________________ Score: L____ R____ Both_______
Near Acuity - Tool used: __________________ Score: L____ R____ Both_______
Last exam:__________ Further comments (see below)

NUTRITION

☐ WIC participant
☐ Referred to WIC
☐ Breast Feeding ☐ Formula
Amount & how often: ____________________

Number of Servings per day

Bread/Cereal ________ Dairy ________
Fat/Sweet/Sugar ________ Fruit ________
Meat/Bean/Egg ________ Vegetable ________
Fluid Intake: water ________ oz. Soda ________
Milk ________ oz. Juice ________

PHYSICAL ACTIVITY

☐ Biking ☐ Basketball ☐ play outside
☐ Skating ☐ Walking ☐ other sports

How many hours screen time/Day? (i.e. TV, Games, PC)
☐ 0-1 hr ☐ 1-2hr ☐ 3-5hrs ☐ 5+hrs

KBH participant currently pregnant? ☐ Yes ☐ No
If "yes", then complete following :
1. Prenatal Record initiated? ☐ Yes ☐ No
2. On prenatal vitamins? ☐ Yes ☐ No
3. Referred for OB/GYN cares? ☐ Yes ☐ No

Referred to:

LABORATORY

Obtain CBC with automated differential in infants between 9-12 months. Obtain CBC with automated differential in males at age 15 and in females at menarche. Annual CBC's with diff are required depending on lifestyle/ health needs, please see Provider Manual. Was CBC obtained? Yes ☐ No ☐ Indicate further follow-up in Plan of Care.

IMMUNIZATIONS

Copy of record in chart
Current ☐
Behind ☐
Unknown ☐
Requested from Parent ☐
Referred to VFC provider ☐

Needs (circle): Rota
HepB DTaP Flu
Hib IPV MMR
MCV4 MPSV4 PCV
Varicella HepA HPV
Other:

DEVELOPMENTAL / EMOTIONAL

Please refer to KMAP Provider Manual for AAP recommended Developmental Tools.
Children < 6 yrs. A completed developmental screening tool **to include the screener's interpretation and report** regarding meeting developmental milestones. If further testing/intervention is required, please include in Plan of Care.

Children 6-21 yrs. A completed developmental screening tool **to include the screener's interpretation and report** or document all developmental/emotional observations found below. Include further testing/intervention needs in Plan of Care.

Developmental Tool used:____

Sleep Habits ____________ Tired / overactive? ________
Discipline: ____________ Vocational concerns? ________
Peer Interaction: ____________ Exercise ________
Grade Level ____________ Average Marks ________
Special Education: ____________ Special Needs: ________
Any emotional or behavioral problems? ____________
Emotional Observations:____
____

DENTAL

Sees Dentist? Yes ☐ No ☐
Last dental exam date: ____/_____/______
times brushes/day: ____________
Dental Referral (annually at a minimum 1-20yr)
Yes ☐ No ☐ ~ Fluoride Varnish? Yes ☐ No ☐

HEARING SCREEN

Maintain in record completed paper hearing screens & report or qualifying hearing screen procedure & report.

Age birth to 4, perform Risk Indicators for Hearing Loss **and** Hearing Developmental Scales Pass ☐ Refer ☐
Hearing Health History >4: Pass ☐ Refer ☐
Or Screen Procedure:____________________

HEALTH EDUCATION AND ANTICIPATORY GUIDANCE

Circle Those Reviewed/ Handouts Given

1. Behavior/Discipline
2. Oral /Dental
3. Development
4. Physical Activity
5. Family Planning
6. Immunizations
7. Lifestyle
8. Nutrition
9. Parenting
10. Safety/Poisons
11. Substance Abuse
12. Self Testicular Exam
13. Self Breast Exam
14. Sexuality
15. Exercise
16. Weapon Safety
17. Other:____________________________

RESULTS/PLAN OF CARE

Screening Results: ____

Plan/Referrals (dental, vision, hearing, dietary, etc):____________________
____
____
____

Screening Providers Signature: ____________________

Recommended Return Date:

Parent/Caregiver and/or Patient informed of KBH Screen findings and verbalizes understanding of findings and recommendations. Yes ☐ No ☐
Parent/Caregiver and/or Patient Signature:____________________
Date: ________________________

(Licensed Physician, ARNP, PA, or Registered Nurse credentialed to perform KAN Be Healthy screens)

form revised 12/6/07

Mandatory Blood Lead Screening Questionnaire

To be completed at each KBH Screen from 6 to 72 months

Does your child: (circle response received) DATE: (MM/DD/YYYY)						
1) **Live in or visit a house or apartment built before 1960?** (This could include a day care center, preschool, the home of a baby-sitter or relative, etc.)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
2) **Live in or regularly visit a house or apartment built before 1960 with previous, ongoing or planned renovation or remodeling?**	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
3) **Have a family member with an elevated blood lead level?**	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
4) **Interact with an adult whose job or hobby involves exposure to lead?** (Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and/or making pottery).	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
5) **Live near a lead smelter, battery plant or other lead industry?** (Ammunition/explosives, auto repair/auto body, cable/wiring striping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten (foundry work).	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
6) **Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?**	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
One positive response to the above questions requires a blood lead level test. Please, remember blood lead level tests are required at 12 and 24 months, regardless of the score. Was blood drawn for a blood lead level test?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Interviewing Staff Initials						

Staff Signature:

Patient Name: ______ I.D. Number: ______:

Revised 12/2007

Sublette's BEST2

Building **E**xcellent **S**tudents **T**oday!

Sublette students, Kindergarten through Sixth Grade, have the opportunity to engage in learning activities to enhance their knowledge in academic studies as well as in enrichment programs.

Sublette's BEST2 will operate from **Tuesday, September 4, 2018 through Thursday, May 9, 2019**. The program hours are from **3:40 until 5:10**.

Enrollment Fee: $35/year for each student OR

$105/yr. for a family of 3 or more students.

Activities to be offered include but are not limited to:

STEAM Labs	Makerspaces	Agricultural Education
Art Education	Community Event Presentations	Cooking
Physical Fitness	Homework Assistance	Tutoring

Please complete this registration to enroll your student in the BEST2 program for the year 2018 – 2019.

Student Name: ____ Grade: __________________

Parent (s) / Guardian (s) Name (s): ____

Contact information: (this number must be accessible between the hours of 3:40 – 5:30)

____

Student Allergies and/or Medical Concerns:

_______________________________ __________________ ____________________________

List of persons **NOT** allowed to pick up your student from the BEST2 program:

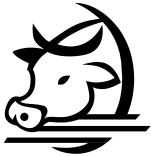
____________________________ ___________________________ _________________________

Is / Are your student (s) bus riders? (Circle one please) YES NO

SUBLETTE USD 374
Identification & Recruitment Parent Survey

Please complete the following information to help us determine if your child/children qualify for the migrant program. This program provides extra academic help for students who may need assistance as well as other benefits. Thank you for your help!

1. Has your family moved into this district within the past 3 years? ☐ Yes ☐ No
(**Note: If you answer "NO" to the above question, do not answer questions #2, #3 & #4.)**
2. Are you now looking for agricultural work? ☐ Yes ☐ No
3. Are you now working in agricultural work? ☐ Yes ☐ No
4. Were you employed in any agriculturally related jobs listed below in Kansas within the last 3 years?
☐ Yes ☐ No


Feed Cattle, Processing, Packaging

Dairy

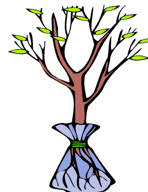
Eggs

Cultivation, Preparation of soil

Fishing

Harvest (fruit and vegetables)

Milling, Cotton


Trees Planting, Cutting

Greenhouse, Nursery, Sod

Parent/Guardian Names	**Present Job/Job Title**	**Last Employment**
Father:______________	______________/______________	__________________
Mother:______________	______________/______________	__________________

Please list all children

First	Last	Sex	School	Grade	Date of Birth	Age

Address: ______________________________________Telephone:_______________________

✕_________________________________ ___________________
Signature of Parent or Guardian **Date**

SUBLETTE USD #374
Encuesta Para Los Padres

Por favor complete la siguiente información para que nos ayude a determinar si sus hijos/a (s) califica para el programa migrante. Este programa provee ayuda académica extra para estudiantes que necesitan asistencia al ígual que otros beneficios. ¡ Gracias por su ayuda!

1. ¿Se ha cambiado a este distrito los últimos 3 años? _______Si _______No

Nota: Si contesto "no" a la pregunta de arriba, no responda a las preguntas #2, #3, & #4.

2. ¿Está buscando trabajo de agrícultural?________Si _______No

3. ¿Está trabajando en trabajo relacionado con agrícultura?_____ Si ___No

4. ¿Ha estado empleado en algún trabajo en Kansas relacionado con agrcultura mencionado abajo durante los últimos 3 años?_________Si ______No

Ganado, Procesando, Empacando

Lucería

Huevo

Cultivando, Preparción de Tierra

Pescado

Cosechando (frutas y verduras)

Mollinos

Árboles Podar, Plantar, Derribar o Cortar

Inverndero, vivero, Cultivar Pasto

Padres/Guardianes Nombres   Trabajo presente/posición de Trabajo   Ultimo Trabajo

Padre: __________________   _______________ / _________________   ____________________

Madre: _________________   _______________ / _________________   ____________________

Por favor escribir todos los nombres de los niños que viven en la casa.

Apellido, Nombre	Sexo	Escuela	Grado	Fecha de Nacimiento	Edad

Domicilio:__________________________________ Telefono: ____________________________________

Firma de Padre/Guardián ____ Fecha _____________

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. 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. The assessments approved by Kansas State Department of Education include: The Language Assessment Scales (LAS)/LAS LINKS/Pre-LAS, the IDEA Proficiency Test (IPT)/Pre-IPT, the Language Proficiency Test Series (LPTS), and the Kansas English Language Proficiency Assessment (KELPA)/KELPA-P. 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.	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 most often speak/use at home?
   English   Spanish   Other (please specify) ________________
3. What language do you most often speak/use with your child?
   English   Spanish   Other (please specify) ________________
4. What language do the adults at home most often speak/use?
   English   Spanish   Other (please specify) ________________

Parent/Guardian Information:

Which language 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.

Has your family moved in the last 36 months to seek or obtain agriculture or fishing related work?
Yes _____No _____

If yes, was the move from one school district to another? Yes _____ No _____

____

Signature of Parent or Guardian   Date

UNIFIED SCHOOL DISTRICT #374, SUBLETTE, KS
Mrs. Rachel Lee Elementary School Principal
P.O. Box 550
Sublette, KS 67877
Phone: (620) 675-2286 Fax (620) 675-2296

The following student has enrolled in our school:

Name:________________________________ Date of Birth:__________

Grade:_____________________ Social Security #:__________________

Enrollment Date:____

Previous School Attended: ____

Address:_______________

Phone:________________________________ Fax:________________

Please send the Following:

A. Withdrawal Form
B. Complete Transcript
C. Test Records
D. Immunization Records
E. Copy of Birth Certificate
F. Copy of Social Security Card
G. Home Language Survey
H. Any Special Programs (Title I, IEP, etc...)
I. All other pertinent information.

Please send the information to:
Sublette Elementary School
Attn: Risa Leonard Stevens
P.O. Box 550
Sublette, Kansas 67877

It is not necessary for parents to sign a release when records are being passed from public school to public school. Note Federal Register, Thursday June 17, 1976 Privacy rights of Parents and Students. Final rule on Education Records; Volume 41 No. 118 Page 24673