Enrollment Information - Summersville R-II School District Enrollment date:_____

Please Provide the following:

- Proof of Residency
- Birth Certificate
- Immunization record
- Social Security Card
- Transcripts or Transcript Release Form
- Individual Education Plan/504 Plan (If applicable)

Student Information:

Student Name: _____ Date of Birth:_____

Gender: M or F Grade:_____

Race:
_____White_____Asian_____Black/AfricanAmerican_____Indian_____Hawaiian____Hispanic
Ethnicity: _____Non-Hispanic/Latino _____ Hispanic

Mailing address: _____City:_____

State:_____ Zip code:_____ County:_____

Does student have an: **IEP**: Y or N **504 Plan**: Y or N

Parent/Guardian Contact information

Guardian Name	Phone	Email	Relationship

Emergency Contacts (someone other than parents)

Name	Phone	Relationship	Allowed to check student out/pick up student

Student name: _____
Parent name: _____

Homeless Identification

☐ No ☐ Yes Are you sharing housing with other persons due to loss of housing, economic hardship, or similar circumstances?

If yes please explain below:

_____

☐ No ☐ Yes Are you currently residing in a motel, hotel, in a car or at a campsite because your home has been damaged or because of economic reasons?
☐ No ☐ Yes Are you currently residing in a shelter?
☐ No ☐ Yes Are you currently living in a temporary housing arrangement due to economic hardship?
Office use only: Homeless ☐ No ☐ Yes Migrant: ☐ No ☐ Yes

Migrant Identification
☐ No ☐ Yes Are you or your family currently engaged in temporary or seasonal agricultural-related work?
☐ No ☐ Yes Have you or your family recently been engaged in temporary or seasonal agricultural-related work?

Primary Language
Is the primary language of the student English? ☐ No ☐ Yes
Is the primary language of the parent/guardian English ☐ No ☐ Yes

If the answer to either of the above questions is no, please specify the primary language preferred? _____

Student Network/Internet User Agreement- Summersville R-II School District

I, _____(student name) have read the information on the Network/Technology usage at Summersville R-II School District and agree to abide by all the policies, rules, regulations and responsibilities contained therein.

_____ _____ _____

Student Signature Date Grade Level

As a parent/guardian of the above named student, I give permission for my child to use the Internet/Email resources provided by the school district and have read the Network

_____ _____

Parent/Guardian Signature Date

Note: Parents/Guardians- if you agree that your son/daughter can use all the resources sign the line above and

Do <u>NOT</u> sign both sections

****

Internet/Email Denial

As the parent/guardian of the above named student, I do not give permission for my child to use the district Internet/Email resource/ I do, however understand that my child may use the computer resources of the school district to complete classroom assignments, and projects etc.

_____ _____

Parent/Guardian Signature Date

Release of Information/Request for Records

In accordance with State and Federal Law, this form authorizes Summersville Public Schools to request written and verbal information for the purpose of legitimate educational interests and planning for:

Name of Student: _____ Date of Birth:_____Grade_____

School/Institution:

_____City_____ State_____

Summersville R-II school district is requesting the following records, if available

- ☐ Transcripts
- ☐ Birth Certificate
- ☐ Attendance records
- ☐ Withdrawal Grades/ Most recent report card
- ☐ MOSIS ID number
- ☐ Health/Immunization Records
- ☐ Disciplinary Reports
- ☐ Standardized test results
- ☐ Psychological/Motor/Occupational/Physical Testing Results

Send the following to the Special Education Director, Dr. Jewel Holloway:

- ☐ Individualized Education Plan IEP
- ☐ Section 504 Records/Plans
- ☐ Evaluation/RED reports
- ☐ Any other documentation pertaining to special education plan for this student

Parent/Guardian Signature/Student Signature (If 18+)

_____ Date:_____

Please send records to
Summersville R-II School District
818 Richards Street
Summersville, MO 65571

Sheri Tharp
Elementary Secretary
tharps@sville.k12.mo.us
Phone EXT 1002

Dr. Jewel Holloway
SPED Director
Hollowayj@sville.k12.mo.us
Phone EXT 2038

Summersville RII School
Health Information Form

This form is required to be updated each school year. Please turn the completed form into the school office. Individuals listed on the student's enrollment form will be individuals contacted if the parent/legal guardian cannot be reached in the event of an illness or injury to the student.

Student's Name:_____ Date of birth:_____
Grade:_____ Teacher:_____
Family Doctor:_____
Last visit:_____ Insurance Y/N Medicaid: Yes/No None
Dentist: _____ Last Dentist visit:_____
Orthodontist:_____ Last ortho visit:_____
Is your child allergic to any medication? Y/N If yes, Please list medication and reaction
_____
Does your child have any other known allergies (environmental, food, etc)? Y/N. If yes please list it and the treatment used: _____
_____

!!A doctors note MUST be on file at the school before food on trays may be substituted !!

Has your child been diagnosed with the following?
Asthma Y/N Triggered by:_____ Treatment:_____
Diabetes Y/N Takes Insulin Y/N Diet Controlled? Y/N What Diet? _____
_____
Epilepsy/Seizures: Y/N Date of last seizure?_____ Describe seizure:__
_____
ADD/ADHD Y/N Any other behavioral problems:_____
Does your child take any medications at home? Y/N At school? Y/N Emergency only? Y/N
If yes, list the medication(s) and reason for taking:_____
_____
Has your child had any previous serious illness, injuries, or surgeries Y/N
If yes please explain:_____
Does your child require vision or hearing correction? Y/N
Please explain:_____
Any other health concerns?
_____

Missouri State Law requires that Summersville R-II School District must keep on file your written permission to medicate your child in the event of minor illness or injury without your permission to medicate the district will provide Emergency Medical Services only. The following medications are on hand at school and are available to your child with appropriate authorization.

Medication Consent form

Please Draw a line through any of the following medications you DO NOT want administered to your child at school:

- Acetaminophen (generic Tylenol) Tabs Liquid
- Ibuprofen (generic Motrin) Tabs Liquid
- Diphenhydramine (generic Benadryl) Tabs Liquid
- Hydrocortisone Cream (anti-itch)
- Triple Antibiotic Ointment
- Tums antacid tablet
- Pepton-Bismol
- Orajel (sore tooth medicine)
- Artificial Tears (eye drops)
- Calamine Lotion
- Cough Drops
- Burn Gel
- Sting Relief

Parental permission to Medicate:
I hereby give my written permission to the Summersville R-II School District to medicate my child with the above medication in the event of a minor injury or illness. I give the school health aid/nurse permission to share my child's health information to employees of the Summersville R-II School District as determined necessary by the school nurse or school administration.

_____

Parent/Legal guardian Date

Parental Permission to Seek Emergency Medical Treatment:
If, in the event of a severe illness or injury as determined by the Summersville R-II School District Health Aide/Nurse or school official, I or my designated responsible care person cannot be immediately notified, I hereby give my written permission for the Summersville R-II School District personnel to seek medical treatment for my child from a physician or the nearest Emergency medical services facility

_____

Parent/Legal guardian Date

Parental Permission to Medication with Prescription Medication
Medicine must be in a pharmacy labeled container, clearly marked with the student's name, the physician's name, the prescription number and date it was ordered, as well as the name and the strength of the medication and directions for administering it. Medication MUST be delivered to the school by an adult. Medicine must not be carried to school by the student. ANY medication sent in with a student will not be administered by the nurse. Any unused medication may be picked up by a parent after it has been discontinued. Twice a day medicines should be given at home, with doses

_____

Parent/Legal guardian Date

One-Time Parent/Guardian Consent to Access Public Benefits and Release Personally Identifiable information

With your consent, your school district is allowed to seek reimbursement from the MO HealthNet (Medicaid) Division for the purpose of payment for some services provided through an individual education program (IEP) under the Individuals with Disabilities Education Act (IDEA) by accessing your child's public benefits

School District Name:_____

Students Full Name:_____ Date of Birth:_____
The MO HealthNet (Medicaid) School-Based Services Program in Missouri:

- Provides partial reimbursement to school districts for services such as occupational therapy, physical therapy, speech/language therapy, behavioral health services, audiology/hearing services,private-duty nursing, personal care service and transportation.
- Does not affect a family's MO HealthNet (Medicaid) insurance benefits.
- Helps school districts offset some of the costs of healthcare provided to children
- It is voluntary and requires parents/guardians to provide written consent for a school district to release information about their child and seek reimbursement from MO HealthNet to help pay for services in an IEP under the IDEA.

If your child receives any of the services listed above and qualifies for MO HealthNet benefits at any time during a school year, we request your permission to release information to allow the school district to access MO HealthNet (Medicaid) to help pay for school-based services.

By signing below, you are indicating the following:

- I understand and give the school district permission to access my or my child's public insurance and release my child's education records and information about the services my child receives through the IEP in order to access MO HealthNet (Medicaid) to help pay for services under the IDEA.
- I understand this may include sharing information with the MO HealthNet Division (MHD), their contracted billing agent, and /or a physician to obtain necessary documentation (e.g. physician scripts, referrals) to receive partial reimbursement for services provided through IEP
- I understand information to be released may include the child's name, date of birth, social security number(If provided). Medicaid ID or other identification, disability type, IEP and evaluations, types of services, times and dates service were delivered, and progress notes
- I understand that this consent will remain in effect at all times the district is responsible for providing IEP services to my child unless revoked by me and that I may revoke my consent at any time by notifying the school district in writing.
- I understand that revoking my consent does not change the school District's responsibility to provide all required IEP services to my child at no cost to me.

_____

Parent/Guardian Signature Date