ENROLLMENT REQUIREMENTS

Appointments are necessary for enrollment

Please call: 993-7530

Attached are forms that need to be completed for enrollment:

1. Shawnee Mission School District Student Enrollment Form
2. Health History Form
3. Medication Permission Form
4. Home Language Survey

All new enrollments *MUST* provide the following:

1) Proof of Residency
   a) TWO major utility bills dated within the last 45 days (electric AND gas or water)
   b) Mortgage or lease agreement dated within the last 45 days
   Driver's License & P.O. Box not acceptable proof of residency
   c) A copy of a Kansas driver's license or government photo ID from legal parent(s)/guardian(s) living in the home. The address must match the residence or provide proof the address has been changed.
2) Transcript of courses and grades from previous school
3) Current immunization records
4) Certified copy of the birth certificate or government issued passport
5) If student is in Special Education, or has a 504 accommodation plan, a copy of their current plan is needed. (*please mention I.E.P. when appointment is made).*
6) If student is residing with someone other than a parent(s), a provider form must be completed through the district residency office prior to enrollment.

SMSD
Shawnee Mission School District

STUDENT ENROLLMENT FORM

FOR OFFICE USE ONLY - SCHOOL INFORMATION

START DATE _____

STUDENT NO_____ SCHOOL YEAR_____ SCHOOL NAME _____ HOME ROOM _____ GRADE_____

NEW ENROLLMENT ☐ RE-ENTRY ☐ 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)		
☐ No, not Hispanic/Latino	☐ White	☐ Black/African American	☐ Asian
☐ Yes, Hispanic/Latino	☐ Native Hawaiian/other Pacific Islander		☐ American Indian/Alaskan Native

PRIMARY LANGUAGE SPOKEN : OTHER LANGUAGE SPOKEN AT HOME:

SCHOOL LAST ATTENDED _____ IS STUDENT CURRENTLY UNDER LONG-TERM SUSPENSION OR EXPULSION? ☐ YES ☐ NO

HAS STUDENT ATTENDED A SHAWNEE MISSION SCHOOL PREVIOUSLY? ☐ YES ☐ NO

PLEASE INDICATE IF STUDENT HAS AN I.E.P. ☐ YES ☐ NO PLEASE INDICATE IF STUDENT HAS A 504. ☐ YES ☐ 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	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

EMAIL ADDRESS :

GUARDIAN 2 LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

EMAIL ADDRESS :

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	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

EMAIL ADDRESS : **(OVER)**

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
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

EMAIL ADDRESS :

ADDITIONAL RESIDENCY INFORMATION

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

☐ In a shelter_____ (name shelter) ☐ In a motel, car, or campsite ☐ In temporary foster care awaiting permanent placement	☐ Alone without parental support(independent living student) ☐ Temporarily with more than one family (due to loss of job, housing etc.)	☐ Temporarily with more than one family in a house, mobile home, or apartment because the family doesn't have a place of their own. ☐ None of these apply

ALL CHILDREN RESIDING AT RESIDENCE

	LAST NAME	FIRST NAME	BIRTHDATE	SCHOOL
1.			__/__/__	
2.			__/__/__	
3.			__/__/__	
4.			__/__/__	

MIGRANT ELIGIBILITY

1. Does anyone in your family work in agriculture, including at a greenhouse or nursery? ☐ Yes ☐ No
2. If yes, have you moved within the past three years? ☐ Yes ☐ 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
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

#2 LAST NAME	FIRST NAME	TITLE	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER

#3 LAST NAME	FIRST NAME	TITLE	RELATIONSHIP TO STUDENT

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ADDITIONAL PHONE NUMBER
( )_____-_____	( )_____-_____	( )_____-_____
☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐OTHER	☐HOME ☐WORK ☐CELL ☐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_____

(PARENT/LEGAL GUARDIAN)

Rev. 03/03/16

SMSD
Shawnee Mission School District

HOME LANGUAGE SURVEY

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

Shawnee Mission School District

HOME LANGUAGE SURVEY

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	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 <u>not</u> 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) _____

If any answer to questions 1-4 indicates a language other than English,

1) Contact the ELL office at 913-993-8671 immediately to schedule an evaluation and

2) Fax the form to 913-993-8679.

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 and date:

_____ _____

Updated 6/4/2013

SMSD
Health Services

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:

☐ ADD/ADHD	☐ Depression/Anxiety	☐ Orthopedic/Bone
☐ Allergies ☐ Seasonal	☐ Dental ☐ Braces/Orthodontia	☐ Serious Injury
☐ Dietary Restrictions	☐ Ear Infections ☐ Ear Tubes	☐ Surgery(s)
☐ Bladder/Bowel	☐ Hearing Impairment ☐ Hearing Aides	☐ Social/Emotional/Behavioral
☐ Blood Disorder	☐ Headaches/Migraines	☐ Stomach Aches
☐ Concussion	☐ Heart Disease	☐ Throat Infections
☐ Cancer	☐ Kidney Disease	☐ Vision: ☐Glasses ☐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 / /

SMSD
Health Services
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.

SMSD
Health Services
Shawnee Mission School District

Medication Permission Form

Student Name _____ Grade _____ Date _____

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
_____ 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.

Healthcare provider name: _____ Phone number _____

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 _____

Revised 4/9/2015