JACKSON HEIGHTS ELEMENTARY SCHOOL

12763 266TH ROAD
HOLTON, KANSAS 66436
PHONE: 785-364-2244
FAX: 785-364-4712

Authorization for release of school records and information to
Jackson Heights Elementary School

To the Principal of _____
Name of School

_____
Address

_____
City, State, Zip

I hereby authorize the release of the information or records of

_____ Grade _____

to Jackson Heights Elementary School for the purpose of enrollment.

Information or records to be released are those indicated below:

Personal Information	_____	Academic Records	_____
Test Records	_____	Attendance Record	_____
Health Records	_____	Other (Specify)	_____

_____
Signature of Person Authorizing

_____

_____
Address

ENROLLMENT CARD

Date_____ School Term 20_____ 20_____

Student_____ Birthday_____ _____ _____
First Middle Last Month Day Year

Grade_____ Age_____ Gender_____ School District of Residence_____

Father's Name_____ Home Phone_____ Cell Phone_____

Mother's Name_____ Home Phone_____ Cell Phone_____

Father's Employer_____ Employer's phone_____

Mother's Employer_____ Employer's phone_____

Home Address_____
Box, Route or Street City Zip

Email Father's_____ Mother's_____

Emergency contact 1._____ 2._____ 3._____

Emergency phone 1._____ 2._____ 3._____

Relationship 1._____ 2._____ 3._____

Day Care Provider_____
Name Address Phone Number

Family Physician_____ Phone_____

List any unusual health problems of this child_____

Primary Race/Ethnicity (circle only one)

0 – Refuse to Designate
1 – American Indian or Alaska Native
2 – Asian
3 – Black/African American
4 - Native Hawaiian or other Pacific Islander
5 – White
6 – Hispanic or Latino

Secondary Race/Ethnicity (circle all that apply)

1 – American Indian or Alaska Native
2 – Asian
3 – Black/African American
4 – Native Hawaiian or other Pacific Islander
5 – White
6 – Hispanic or Latino

First day student will attend Jackson Heights_____

Student Health & Medication Form

Student Name: _____ Birth Date: _____ Grade: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Health conditions. *Please check all that school staff should be aware of.*

- ☐ Asthma. Uses inhaler ☐ Yes ☐ No
  Will inhaler be sent to school? ☐ Yes ☐ No
- ☐ Bone disease/fractures
- ☐ Diabetes
- ☐ Ear infections (chronic/numerous)
- ☐ Emotional disturbances
- ☐ Frequent headaches/migraines
- ☐ Frequent stomach aches
- ☐ Glasses
- ☐ Contact lenses
- ☐ Digestive problems
- ☐ Heart/blood disease
- ☐ Attention deficit disorder
- ☐ Kidney disease
- ☐ Physical handicap
- ☐ Seizure disorder
- ☐ Special dietary regimen
- ☐ Surgeries
- ☐ Throat infections (chronic/numerous)
- ☐ Head injuries
- ☐ Hearing impairment
  Uses hearing aid ☐ Yes ☐ No

Allergies. List all known allergies for this student (include medications, foods, insects, environmental, etc.):

A physician has prescribed the use of an Epi-Pen for _____ allergy. ☐ Yes ☐ No

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Please complete this section if your child has been diagnosed with ANY of the items above.

Number of times child has been taken to an emergency room for an episode in the past 12 months:

Describe the type of symptoms your child experiences:

Is there anything that triggers the symptoms?

What usually helps if an episode occurs?

Medications child takes for this condition: Name, dose, frequency:

List any other medications this student takes on a routine basis:

Asthma: Does your child use a peak flow meter? ☐ Yes ☐ No If yes, what is the child's best peak flow?

I know of no health reason(s), other than the information indicated on this form, why my child should not participate in any school activity. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. I understand that it is my responsibility to provide emergency medications my child may need. Transportation by ambulance is authorized if required.

Parent/Legal Guardian Signature _____ Date: _____

Medication Permission Form

Student Name: _____ Grade: _____

Permission for the administration of <u>over-the-counter medications</u> during school attendance.
I give my permission for authorized school personnel to administer over-the-counter medications/treatments to the above named student for minor discomforts and injuries. I understand that these medications will NOT be given for fever.

Please ***<u>INITIAL</u>*** all the following to allow authorized personnel to give:

_____ Cough drops

_____ Acetaminophen (equivalent for Tylenol)

_____ Ibuprofen (Advil, Motrin or equivalent)

_____ Antacids

Note: Stock bottles of acetaminophen, regular ibuprofen and cough drops are provided in each building. If students bring any over-the-counter medication (including junior strength ibuprofen) from home, it must be in the original container and be clearly labeled with child's name.

I understand that any school employee who administers any of the above medications, in accordance with the prescription and/or over-the-counter directions, to my student shall not be liable for damages as a result of an adverse reaction suffered by the student due to this administration. *I further acknowledge that the above student has taken the medications(s) previously (or the initial dosage) and has experienced no adverse reactions.*

Parent/Legal Guardian Signature _____ Date: _____

Permission for the administration of <u>prescription medications</u> during school attendance.

Medication: _____ Dosage: _____ Date of initial dose: _____

Reason for Rx: _____

Time of day Rx to be given: _____ Anticipated duration of Rx at School: _____

Physician comments:

Physician signature*: _____ Date: _____

Parent/Legal Guardian Signature*: _____ Date: _____

**REQUIRED for all students in grades K-12 in order to authorize the dispensation of above prescription medication(s) at school.*

Note: Any prescription medication is to be brought to school in the original container appropriately labeled by the pharmacy stating:

1. Name of the student
2. Name of medication
3. Dosage and time to be administered
4. Number of days to be administered
5. Current prescription date

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

School: _____

Name of Student: _____

Address: _____

Phone: _____ Date of Birth: _____

Name of Parent or Guardian: _____

Relationship to Student: _____

Address (if different than above): _____

Phone (if different than above): _____

I hereby authorize Terri Oswald to release immunization information in his/her/their possession relating to the above-named Student to:

_____ County Health Department

_____ (Health Provider/Physician)

_____ (USD _____/ School Official)

Kansas Immunization Registry (Immunization information disclosed to the registry will be used for purposes of assessment and reporting to prevent disease.)

I affirm that I am authorized to consent to release of medical information on behalf of the Student. I understand that this authorization will expire when the Student is no longer enrolled in the above-named school and that I may revoke this authorization in writing at any time.

Parent / Guardian Signature: _____ Date: _____

The foregoing was acknowledged before me this _____ day of _____, 20____.

By: _____

CONSENT FOR TREATMENT

(We) (I)_____, the parent(s) and /or legal guardian(s) of_____consent to and authorize, for the school year 2020-2021, a qualified representative of Jackson Heights Schools to authorize medical treatment, including any necessary surgery or hospitalization, for (My) (Our) above-named dependent(s), for any injury or illness of an emergency nature he/she (they) will incur while at Jackson Heights Schools or while participating in sports and organized athletics, or activities at and for Jackson Heights Schools by any physician and dentist licensed in accordance with the provisions of the Kansas Healing Arts Act, Kansas Statutes Annotated 65-2801 and any hospital.

I understand that the terms hereof apply to any injury, illness or other medical problem or emergency that arises as a result of or in connection with any aspect of school participation at Jackson Heights Schools, including classes, activities, tryouts, practice, meetings, games and travel. I also understand that reasonable efforts will be made to contact parents or legal guardians before any serious or involved medical treatment.

I also hereby grant permission for qualified athletic trainers at Jackson Heights Schools who are acting under the express direction and guidance of a physician to render any preventative medical treatment, first aid, emergency medical care, or rehabilitative medical treatment deemed reasonably necessary to protect the health and well-being of the above named student while participating in athletics.

(We) (I) agree to pay and assume all responsibility for all medical and hospital expenses and any services of an emergency nature, and charges for (my) (Our) dependent(s).

(We) (I) acknowledge and agree that Jackson Heights School, is not responsible for any medical hospital expenses and charges that are incurred in the medical treatment or hospitalization of our dependent(s).

***NOTE: Jackson Heights Schools carry limited insurance coverage against injuries on all students enrolled at Jackson Heights Schools. Limited coverage is provided for students involved in classroom activities, sports, and other extracurricular activities. Essentially, with limitations, our policy covers the uninsured student and deductibles or limitations by the parents' or guardians' insurance company. Insurance forms may be obtained from the office. After the school portion of the claim is filled out by school officials it becomes the parent's or guardian's responsibility to see that the form reaches the proper destination and instructions on the form are carried out.

*A photocopy of this document shall have the same force and effect as the original.

Parent(s) home phone number _____

Mother's work number_____

Father's work number _____

Insurance Company_____

Policy Number_____

Grandparents' or other relatives' number_____

Parent's signature_____

Medical Statement to Request School Meal Modification

Important! School Food Authorities are required to make substitutions to meals for children with a disability that restricts the child's diet on a case-by-case basis and only when supported by a written statement from a State licensed healthcare professional. If you have questions about this form, the school contact named in Part A below will assist you.

Modifications to Accommodate a Disability: A school is required to make meal modifications prescribed by a medical authority to accommodate a student's disability.

Definition of Disability: Under Section 504, the ADA, and Departmental Regulations of 7 CFR part 15b define a person with disability as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment. "Major life activities" are broadly defined and include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

This form must be completed by a "medical authority" that is authorized by Kansas state law to write medical prescriptions: licensed physician (MD or DO) OR a physician's assistant (PA) or an advanced registered nurse practitioner (APRN) authorized by their responsible licensed physician.

Part A. Student, Parent/Guardian & School Contact Information – To be completed by a parent/guardian or school contact person.

Student's Name:	Date of Birth:	School:
Parent/Guardian's Name:	Parent/Guardian's Phone:	
School Contact's Name:	School Contact's Phone:	

Part B. Prescribed Diet Order – This part must be completed by a medical authority as specified above.

1. Description of the child's physical or mental impairment related to the prescribed diet order and major life activity affected.
   Example: Allergy to peanuts affects ability to breathe.

2. Explanation of what must be done to accommodate the disability (please describe in detail to ensure proper implementation):

Omit Foods Listed Below:	Substitute Foods Listed Below:

Modified Texture: ☐ Not Applicable ☐ Chopped ☐ Ground ☐ Pureed

Modified Thickness of Liquids: ☐ Not Applicable ☐ Nectar ☐ Honey ☐ Spoon or Pudding Thick

Special Feeding Equipment: ☐ Not Applicable ☐ Special Feeding Equipment _____
(e.g. large handled spoon, sippy cup, etc.)

3. Medical Authority's Information:

Signature: Title:

Printed Name:	Phone:	Date:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff and to follow the prescribed diet order for my child's school meals. I also give permission for my child's medical authority to further clarify the prescribed diet order on this form if requested to do so by school personnel.

Parent/Guardian's Signature: Date:

Talent Release Form

Publication of a student's photo:

I hereby assign and grant North Jackson USD 335 the right and permission to use and publish the photographs/film/videotapes/electronic representation and/or sound recordings made of _____, and I hereby release North Jackson USD 335 from any and all liability from such use and publication.

Sale of district publications:

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of North Jackson USD 335, and I specifically waive any right to any compensation I may have for any of the forgoing.

☐ Yes ☐ No

Note: A "Yes" is required to have student photo included in the yearbook.

Publication of student work:

I hereby assign and grant North Jackson USD 335 the right and permission to use and publish the written work/photographs/film/videotapes/electronic representation and/or sound recordings created by _____ , and I hereby release North Jackson USD 335 from any and all liability from such use and publication.

Sale of district publications:

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said written work/photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of North Jackson USD 335, and I specifically waive any right to any compensation I may have for any of the forgoing.

☐ Yes ☐ No

Note: The student maintains the copyright and can personally use his/her work, but the district may also use the work.

Student Name: _____

Student Signature: _____

Parent/Guardian Signature: _____

Date: _____

USD 335

TELEPHONE CONSUMER PROTECTION ACT OPT IN CONSENT FORM

USD 335 utilizes an automated parent notification system called Bright Arrow to quickly and efficiently notify parents of important school and district information. Due to recent changes to the Telephone Consumer Protection Act (TCPA), parents are now **required** to **"opt in" to receive automated communications on their mobile device.** This means parents must provide express consent to receive general messages through automated calls and SMS text messages on their mobile device(s). Such notices include information regarding school closures/delays, upcoming school activities and more.

Please note that you can revoke consent to receive these messages at any time. Opting out still allows you to receive direct phone calls from staff about your child.

Please take a moment to fill out this consent form indicating your desire to receive these important messages in the future. Only one form is required per family.

PARENT/LEGAL GUARDIAN CONSENT:

I, _____ (PRINTED parent/guardian name) give USD 335 and its schools permission to contact me via my cellular device for automated phone calls and SMS text messages for general messages. I understand that emergency notifications are excluded from this permission and will be sent as normal. By signing, I certify that I am the owner of this cellular device and its user contract.

Student names that attend USD 335:

_____ _____

_____ _____

_____ _____

Parent/Legal Guardian Signature and Date *Cellular Number(s)*

Transportation/Early Release Information

P _____
S _____
CC _____

Child(ren)'s Name: _____

Grade: _____

Parent Name(s): _____

Address: _____

Phone: _____ _____
Mom Phone Number Dad Phone Number

(If child is being transported by a parent, please write "No Bus Needed" on lines below)

Bus Pick-Up Address: _____

Bus Drop-Off Address: _____

Secondary Drop Off Name/Address/Phone Number (grandparents, etc):

_____

Child Care Drop Off Name/Address/Phone Number:

_____

Other: _____

In case of an early release day due to bad weather my child is to be:

_____ Delivered to normal drop off

_____ Delivered to _____

_____ I will pick my child up from school.

Additional important transportation information:

_____

_____

_____ _____
Parent Signature Date