

Enrollment Form for Bldg 3 - Dexter Elementary School

First Name:		Middle:		Last Name:	
Preferred Name:		Grade:		Birth Place:	
Race:		Grade:		DOB:	
Amer. Indian or Alaska Native		Asian		Black or African American	
Native Hawaiian/Pac Islander		White		(underline)	
Hispanic/Latino? Yes No (underline one)		Gender:		Home Lang.:	
Access Internet?		Cell #		Email:	
PRIMARY HOUSEHOLD (STUDENT RESIDES AT)					
Mailing:			Street:		
City:		State:	Zip:	City:	
State:		Zip:	State:		Zip:
Information for adults living at the above address.					
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account:	
Email:		Wk Email:		Home #	
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account:	
Email:		Wk Email:		Home #	
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account:	
Email:		Wk Email:		Home #	
ALTERNATE HOUSEHOLD (NON CUSTODIAL)					
Mailing:			Street:		
City:		State:	Zip:	City:	
State:		Zip:	State:		Zip:
Information for adults living at the above address.					
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account:	
Email:		Wk Email:		Home #	
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account:	
Email:		Wk Email:		Home #	
ALTERNATE HOUSEHOLD (NON CUSTODIAL)					
Mailing:			Street:		
City:		State:	Zip:	City:	
State:		Zip:	State:		Zip:
Information for adults living at the above address.					
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account:	
Email:		Wk Email:		Home #	
Name:		Relationship:		Employer:	
Work #		Cell #		POL Account:	
Email:		Wk Email:		Home #	
EMERGENCY CONTACTS: Enter additional contacts not listed above.					
Name:		Relationship:		Email:	
Home #		Work #		Cell #	
Name:		Relationship:		Email:	
Home #		Work #		Cell #	
Name:		Relationship:		Email:	
Home #		Work #		Cell #	
Emergency Medical Information					
Physician:		Phone:		Hospital:	
Medical Notes:					
Daycare Information (if applicable)					
Provider:				Phone:	
SIBLINGS (other students living at same address)					
First Name	Middle Name	Last Name	Grade	Birthdate	School Name

Completed By: _____ Signature: _____ Date: _____



USD #471 DEXTER SCHOOLS



311 N. MAIN STREET-DEXTER, KANSAS 67038-PHONE: 620-876-5415

USD #471 Student Permissions Sheet

Student's Name: _____ Grade: _____

PARENT/LEGAL GUARDIAN CONSENT 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. I give U.S.D. 471 and its schools permission to contract me via my cellular device for automated phone calls and SMS text messages for general messages. I understand that emergency notification s 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, I also am taking responsibility for other phone numbers I have given.

Yes _____ No _____

Authorized Student Data Disclosures in accordance with the Student Data Privacy Act and board policy IDEA, Student data submitted to or maintained in a statewide longitudinal data system may only be disclosed as follows. Such data may be disclosed to:

The authorized personnel of an educational agency or the state board of regents who require disclosures to perform assigned duties; and

The student and the parent or legal guardian of the student, provided the data pertains solely to the student.

Yes _____ No _____

Emergency Treatment Authorization If a parent or authorized person(s) cannot be reached, I authorized school officials, in the event my child is injured or in need of medical attention, to take emergency action at the parent/guardian's expense.

Yes _____ No _____

In-District Field Trip Permission From time to time your student will be taken off school grounds within the district for educational purposes. You will be notified prior to these trips. I give my permission for my child to be taken off school grounds for educational purposes. *If your child will be taking a trip outside the district, a separate permission slip will need to be signed before your student can participate.*

Yes _____ No _____

Media Permission I acknowledge and authorize, release and/or otherwise consent of my child, to be the subject of photographs, video or audio recordings webcasts, or combinations thereof, that are taken, recorded at a school or school related activities. Furthermore, these media products are allowed to be posted on the school's website, social media, local newspapers, or other news outlets.

Yes _____ No _____

Release of Immunization Information I hereby authorize USD 471 to release information to the Kansas Immunization Registry for this student. The 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 the release of medical information on behalf of this student. I understand that this authorization will expire when the student is no longer enrolled in school and that I may revoke this authorization in writing at any time.

Yes _____ No _____

Student Access Contract As the parent/guardian of this student, I have read the terms and conditions of the Acceptable Use Policy (AUP). I recognize that the district is making every attempt to restrict access to all inappropriate materials. However, I accept full responsibility for my child's compliance, and, hereby, give my permission for my child to use the internet. Selecting YES will indicate you are willing for your child to participate in using technology according to the policy.

Yes _____ No _____

Parent's Signature: _____

Parent's Cell Number(s) _____

Student's Signature: _____

Student's Cell Number (Grades 9-12 only) _____

USD #471 DEXTER SCHOOLS

Laptop Agreement

- I will take good care of my Laptop and know that I will be issued the same Laptop each year.
- I will never leave my Laptop unattended in an unsecured or unsupervised location.
- I will never loan out my Laptop to other individuals.
- I will know where my Laptop is always.
- I will keep food and beverages away from my Laptop as they may cause damage to the device.
- I will not disassemble any part of my Laptop or attempt any repairs.
- I will protect my Laptop by always carrying it in a secure manner to avoid damage.
- I will use my Laptop in ways that are appropriate for education.
- I understand that the Laptop I am issued is subject to inspection at any time without notice and remains the property of the USD #471 School District.
- I have read and will follow the policies outlined in the Laptop Policy Handbook and the District Acceptable Use Policy while at school and outside of the school.
- I will file a police report in case of theft or damage caused by fire.
- I will be responsible for all damage of loss caused by neglect or abuse.
- I agree to pay the full replacement cost of my Laptop, power cord/charger, in the event that any of these items are lost or intentionally damaged.
- I agree to return the Laptop, power cord/charger in good working condition at the end of the school year.

Student Name: _____ (Please Print)

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

DEXTER USD 471

LUNCH CHARGE POLICY

By law, any school lunch program that participates in and receives Federal reimbursement monies must operate in the black. When outstanding bills for unpaid breakfast and/or lunch bills become excessive to the point of jeopardizing the overall program, action must be taken. Thus the Board of Education of USD 471 is enacting the following policy regarding student or adult breakfast/lunch charges following ample notification of said parent or adults:

Students will be allowed a maximum of five (5) meal charges. Following 5 charges, and upon the sixth (6), the student or adult shall be placed on a C.O.D. basis until all charges are updated.

Please refer to the front of your school calendar where you find monthly lunch and breakfast prices for the school year.

Notifications may be mailed, emailed, or by phone call if payment is needed for a student account. If money for meals is not received in the office within the 5 charges allowed, you will be ask to send a sack lunch with your child.

By signing below, I understand and accept the lunch charge policy.

Date: _____

Parent/Guardian Signature: _____

USD #471 Dexter Schools School-Parent Compact

The school-parent compact is a written agreement between teachers and parents. It is a document that clarifies what families and schools can do to help children reach high academic standards. The compact is a written commitment and serves as a clear reminder of everybody's responsibility to take action at school and at home so that children can learn what is required of them. The purposes of this agreement are to help parents and teachers come to a consensus on the responsibilities of the individuals influencing student achievement. If the compact is taken seriously and implemented effectively, it will assure that there will be support for the academic success of the student by enhancing effective communications between school and the home.

As a Parent – I promise to:

- Let the teacher know if my child has any problems with learning
- Use reading and math materials the school sends home each week to help my child
- Read to my child 20 minutes a day
- Keep a list of new words, and link letters to sounds
- Play number games with my child every week
- Help my child see how to use reading and math to pursue his/her interests and goals

As a Student – I promise to:

- Let my teacher and family know if I need help
- Read on my own and with my family every day
- Work on my math and reading skills at home, using the materials my teacher sends home
- Write down assignments, do my homework every day, and turn it in when it's due
- Write a report each week about a TV program I watch

As the Teacher – I promise to:

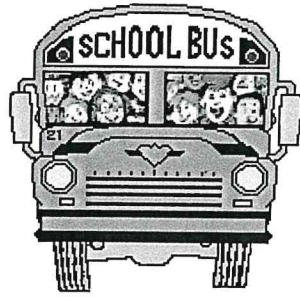
- Create a partnership with every family in my class
- Monitor student progress in reading and math and update parents monthly
- Make sure all students get help as soon as it's needed
- Send home learning materials in math and reading
- Explain my approach to teaching, expectations, and grading system to students and their families
- Continually work on my teaching strategies so that I can successfully teach all children
- Assign work that is relevant and interesting
- Make sure students understand the assignment and what they'll learn from it, and grade it promptly

Parent Signature

Student Signature

Teacher Signature

2022-2023



DEXTER USD 471

PERMISSION TO ATTEND FIELD TRIP OR SCHOOL ACTIVITY

Dear Parents,

Welcome to a new school year! We are looking forward to many exciting events for your child. One of those exciting events is the field trip. Everyone looks forward to this unique opportunity for enrichment with opportunities not available in our community.

This year, we would like to take the hassle out of permission forms for students, parents, and teachers alike. You will sign one form for the whole year. This form will be signed at the beginning of the year and will give permission for your child to go on all field trips provided throughout the year. You will be notified before each trip with all the details of the upcoming event. If no response is received from the home, then the child will be considered a part of that trip. If you do not want the child to go, then you may let the teacher know at that time.

I also give consent for a physician or dentist to provide emergency care for my child(ren) in the event he/she is injured and the sponsor, or hospital, is not able to notify me and emergency treatment is necessary. Attempts shall be made to reach parents if a child is injured.

Please sign the following yearly field trip permission slip and return to your child's teacher. Thank you!

Looking forward to a great year!

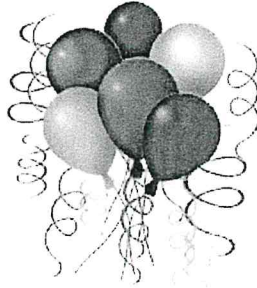
Elementary Staff

_____ has my permission to go on field trips throughout the year.

Signature of Parent or Guardian

Date

2022-2023



Subject: CLASS PARTIES

Dear Parent,

As you know, parties are an important part of a student's school life. We need your help! Please mark the party or parties you would like to help with. This means sending treats such as; goodies, napkins, cups, drinks, favors, etc. I will pass this information on to our Homeroom parent. They will be in contact as to the time of the party and the date. THANKS FOR YOUR HELP!

Please check the one you will help with. If you have a preference as to the thing you would like to supply, please make a note.

- _____ Halloween - October
- _____ Christmas - December
- _____ Valentine's Day - February
- _____ Easter - March or April

Would you be willing to serve as Homeroom parent?

Child's Name

Parent's Name & Phone Number

**Authorization for Self-Administration
of Asthma Medication, K-12**

...to be renewed annually...

Return to School Nurse

**Parent to
Complete:**

Name of Student: _____ Date of Birth: _____ School: _____
Grade: _____

The above student has been instructed on self-administration of medication, and I hereby give my permission for him/her to administer at school as ordered the medication(s) listed. I understand that it is my responsibility to furnish this medication. I acknowledge that the school district and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from the self-administration of medication and agree to release, indemnify and hold the school, and its officers, employees and agents, harmless from and against any claims relating to the self-administration of such medication.

I authorize USD 471 School Nurses to exchange information regarding this student's health care and treatment plan with:

Physician _____ Clinic: _____
Address _____
Phone _____

Signature of Parent _____ Date _____
Phone: Home _____ Work _____
Cell _____

IMPORTANT NOTES: * The student shall carry, for the purpose of self-administering, only a single day's supply of medication, with the exception of inhalers. The medication must be in the original, completely labeled container. If a prescription, it should bear the pharmacy label with correct, current dosage information.

* In order for a student to have access to emergency medications at all times, it is recommended that an additional supply of the listed self-administered medication(s) be kept at the school.

=====

****For School Nurse Use****

The above student has demonstrated the skills necessary for responsible self-administration of medication(s). Yes _____ No _____

school nurse signature date _____

Teachers responsible for supervision of this student have been notified of permission to carry listed medication(s) and self-medicate on this date _____.

Names of teachers notified:

AUTHORIZATION FOR MEDICATION/PROCEDURE TO BE ADMINISTERED AT
SCHOOL & FIELD TRIPS

Name of Student: _____ Date of Birth: _____

Grade/Teacher: _____

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school as indicated by my child's physician accordingly below. I understand that I must provide any prescribed medication in its original labeled container. I also acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber related to the specific treatment in question, including communication concerning: 1. the prescription or treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions); 2. implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule); 3. student outcomes from the treatment (e.g., questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); 4. and other pertinent issues related to the student's diagnosis, condition, or treatment.

Parent Signature

Parent (Printed Name)

Today's Date

Home/Cell Phone Number

Work Phone Number

Current Diagnosis(es): _____

PHYSICIAN MEDICATION AND/OR TREATMENT ORDERS: (please specify)

Medication Name

Treatment/ Dosage Time

Frequency

Special Instructions: _____

I authorize USD 471 Dexter School Nurses to exchange information regarding this student's health care and treatment plan with:

Physician: _____ Clinic: _____

Address: _____ Phone: _____

USD 471 Medical Form

NAME OF STUDENT _____

DATE OF BIRTH _____

NAME OF PARENT/GUARDIAN _____

HOME PHONE _____

WORK PHONE _____

IN CASE OF EMERGENCY CONTACT PARENTS

FAMILY DOCTOR _____

/OR _____ PHONE _____

OFFICE PHONE _____

DENTIST _____

OFFICE PHONE _____

A. Please note any health problem, vision, hearing, or emotional concerns which may limit full participation in the classroom.

B. Check if student has a history of:

☐ asthma ☐ sensitive skin ☐ glasses/contacts ☐ nosebleed
☐ earache ☐ sinus trouble ☐ seizures ☐ high blood pressure
☐ fainting ☐ frequent colds ☐ headache ☐ motion sickness
☐ tonsillitis ☐ diabetes ☐ bed wetting ☐ allergies (i.e. seasonal, food) describe below
☐ eye infection ☐ bronchitis ☐ kidney problem

C. Does student use an Epi-Pen? Yes/No Inhaler? Yes/No

D. Does student take any prescription medications? If, yes please list.

E. Over the Counter Medications (OTC):

I permit USD 471 authorized personnel to administer the following OTC Medications:

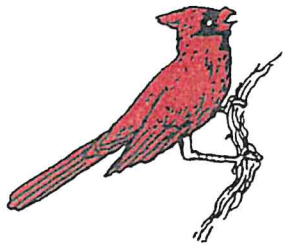
Acetaminophen (Tylenol)		Ibuprofen (Motrin)	
Diphenhydramine (Benadryl)		Neosporin (Antibiotic Ointment)	
Hydrocortisone 1% Topical		Tums	

In case of emergency, I hereby give permission to the physician selected by the school to provide necessary treatment for my child. Initial _____

I authorize USD 471 to share this information with staff and authorized personnel as needed. Initial _____

I authorize information contained on the Kansas Certificate of Immunizations to be released to the Kansas Immunization program for the purpose of assessment and reporting. Initial _____

Parent/Guardian signature: _____ Date: _____



Dexter Unified District 471

Telephone (620) 876-5415
Fax Number (620) 876-5548
P.O. Box 97 • Dexter, Kansas 67038

ADMINISTRATION
K.B. CRISS
Superintendent/Principal

DONNA M. HILL
Secretary/Clerk

Student Records Request

To: Registrar

School: _____

Fax #: _____

Student Name: _____

The above named student has enrolled at USD #471 Dexter Schools.

Please send all transcripts, health, test records, physical forms and IEP's.

Thank you,
Stacy Walker
Secretary

Please fax or email me at USD #471 Dexter Schools

FAX:620-876-5548

Email: swalker@usd471.org

Federal Law 99.31: No parent signature required for educational records sent to another educational agency.