

Enrollment Form for Bldg 1 - Dexter High School									
First Name:			Middle:			Last Name:			
Preferred Name:			Grade:			Birth Place:		DOB:	
Race: 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:	
Information for adults living at the above address.									
Name:			Relationship:			Employer:			
Work #			Cell #			POL Account:		Receive Printed Mailings:	
Email:			Wk Email:			Home #			
Name:			Relationship:			Employer:			
Work #			Cell #			POL Account:		Receive Printed Mailings:	
Email:			Wk Email:			Home #			
ALTERNATE HOUSEHOLD (NON CUSTODIAL)									
Mailing:					Street:				
City:		State:		Zip:		City:		State: Zip:	
Information for adults living at the above address.									
Name:			Relationship:			Employer:			
Work #			Cell #			POL Account:		Receive Printed Mailings:	
Email:			Wk Email:			Home #			
Name:			Relationship:			Employer:			
Work #			Cell #			POL Account:		Receive Printed Mailings:	
Email:			Wk Email:			Home #			
ALTERNATE HOUSEHOLD (NON CUSTODIAL)									
Mailing:					Street:				
City:		State:		Zip:		City:		State: Zip:	
Information for adults living at the above address.									
Name:			Relationship:			Employer:			
Work #			Cell #			POL Account:		Receive Printed Mailings:	
Email:			Wk Email:			Home #			
Name:			Relationship:			Employer:			
Work #			Cell #			POL Account:		Receive Printed Mailings:	
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 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, 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) \_\_\_\_\_

## Alcohol Screening Acknowledgement – USD #471 Dexter Schools

*A student's participation in any extracurricular activity, including, but not limited to, sports and dances, is a privilege, not a right; therefore, students who wish to take part in extracurricular activities, and their parents, guardians or other responsible persons, will be required to sign a form acknowledging that they have read and understand the alcohol screening policy.*

Extracurricular activities are an important part of the overall educational program at Dexter High School. A well-rounded education is not only academically oriented, but also includes physical, social, and emotional development. We at Dexter High School believe students will be productive, responsible citizens of the society in which they live.

As condition of admission to school-sponsored dances, a signed copy of this form must be on file at the school to acknowledge that I have received, read, and understand the attached Alcohol Screening policy. Thank you in advance for supporting a safe and enjoyable evening for our students.

\_\_\_\_\_  
Student/Guest Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

### Handbook

**Breathalyzer Testing** In accordance JDDA, no student shall possess, use, be under the influence of, sell, or transfer any alcoholic beverage on school property, at any location of a school-sponsored activity, or in route to or from school or a school-sponsored activity. Violation of this policy shall constitute reason for disciplinary action including suspension and/or expulsion from school and suspensions or dismissal from athletic teams. (Refer to policy listed above on procedures/consequences and athletics/extra-curricular)

1. When an administrator has reasonable suspicion that a student is under the influence of alcohol at school or a school-sponsored event, the student shall be given the option to take a breathalyzer test. If screening results are negative, no action will be taken. A student testing positive on the first test will be administered a second test fifteen minutes later. If the student tests positive on the second test or if the student declines to take the test when reasonable suspicion exists, he/she shall be subject to appropriate disciplinary action as set out in the DHD student handbook.
2. Indications of reasonable suspicion of alcohol consumption may include, but are not limited to, such characteristics as alcohol odor, slurred speech, unsteady gait, lack of coordination, presence of an alcohol container, bloodshot or glazed eyes, marked change in personal behavior, a report by a third party of a student's consumption of alcohol or other similar information, or behavior that is risky, aggressive, or disruptive.

The following steps will be followed if a student tests positive for a second time:

1. The parents or guardians will be notified;
2. The superintendent or his designee shall be notified;
3. If the student is in possession of an illegal item a referral will be made to law enforcement;
4. No student will be allowed to drive him or herself home if he/she has received a positive breathalyzer test result.
5. Law enforcement may be contacted if school personnel are unable to contact a parent or legal guardian.

If deemed medically necessary by the supervising administrator, a student testing positive or refusing to take the test may be transported to the emergency room of the nearest hospital if the student's parents cannot be contacted or will not be readily available to pick the student up. The student shall be accompanied by a staff member designated by the supervising administrator. The student shall be appropriately supervised by staff while awaiting medical treatment, the arrival of the parents/guardians, and/or during transportation.

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:** \_\_\_\_\_

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: \_\_\_\_\_

**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 \_\_\_\_\_

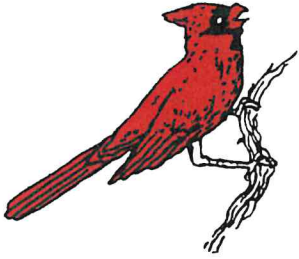
school nurse signature date \_\_\_\_\_

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:

\_\_\_\_\_



## 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](mailto:swalker@usd471.org)

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