

MIDDLE SCHOOL SUMMER ACADEMY!



JOIN US JUNE 4TH-JUNE 28TH FOR FUN, FRIENDS AND LEARNING!

INCOMING 6TH GRADERS-INCOMING 8TH GRADERS WELCOME!

**SUMMER SCHOOL WILL BE HOSTED AT DANIEL BOONE
ELEMENTARY AND BLACK HAWK MIDDLE SCHOOL.**

STUDENTS WILL ATTEND 7:45-2:45, MONDAY-THURSDAY.

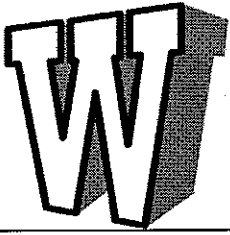
TRANSPORTATION WILL BE PROVIDED.

BREAKFAST AND LUNCH WILL BE PROVIDED, FREE OF CHARGE,
TO ALL STUDENTS.

STUDENTS WILL RECEIVE INSTRUCTION IN READING, WRITING
AND MATH. EXPLORATORY CLASSES WILL CONSIST OF HANDS-
ON ACTIVITIES, SCIENCE EXPERIMENTS AND OTHER PROJECT
BASED LESSONS.

ALL STUDENTS WILL ATTEND PE OR TECHNOLOGY FOR 30
MINUTES EACH DAY AS THEIR SPECIAL.

**ENROLLMENT FORMS MUST BE COMPLETED AND
RETURNED BY APRIL 16TH, 2012. THIS WILL
ENSURE YOUR CHILD'S PLACE IN THE PROGRAM.**



Warren County R-3 School District

302 Kuhl Avenue, Warrenton, Missouri 63383

Phone 636-456-6901 Fax 636-456-7687

Individual Student Information Sheet

OFFICE USE ONLY:

DBE

WRE

RBE

BHMS

WHS

Revised for Summer School 02/2012

Family Name: _____

Today's Date: ____/____/____

Student Name: _____

Grade: _____
(2012-2013 school year - Summer School)

Street Address: _____

City: _____ State: _____ ZIP _____

Mailing Address: (if different) _____

City: _____ State: _____ ZIP _____

Please be advised that if the state eliminates funding for summer school, Warren CO R-III School District will cancel this program for Elementary and Middle School Students. This could happen as late as mid-May.

FOR OFFICE USE ONLY

Data Entry Complete by: _____

Date Completed: ____/____/____

Appropriate Paperwork sent to other schools:

DB WR RB BHMS WHS

Obtained Needed Not Applicable

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Academic / Grade Records and Attendance |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Birth Certificate (Optional) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Custody Documents and or Guardianship Papers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Discipline Records |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Family Registration Sheet |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Health History |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IEP/Diagnostic Info. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immunization Records |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Language survey/ Residency information |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lunch application (if applicable) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medication Authorization and policy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Proof of Residence (utility bill, rental agreement or loan documentation with current address) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Residency Waiver |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Student Information Sheet |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Student Internet Agreement |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Student Permissions Sheet |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Transportation Information |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |



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Individual Student Information Sheet

OFFICE USE ONLY: DBE WRE RBE BHMS WHS

Student Information

Student First Name: _____ Today's Date: ____/____/____

Middle Name: _____ Grade to enter: _____

Last Name: _____ Date of Birth: ____/____/____

Previous name if different: _____ Preferred Name: _____

First _____

Middle _____

Last _____

Gender: Male Female

Ethnicity: Is this student (or one of the parents) of Hispanic/Latino origin? No Yes

Race: Please check all that are appropriate

- | | | |
|---|--|---|
| <input type="checkbox"/> White | <input type="checkbox"/> American Indian | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Asian | |

U.S. Citizen yes no

State or Country of Birth: _____

Birth Certificate provided: (optional) yes no

Primary language of this student spoken at home: _____

Do you require written school announcements/information in a different language? Yes No

If so, which language(s) is required? _____

Special Services

Special Services and/or diagnoses student had at a another school. Please Check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Speech/Language Disorder |
| <input type="checkbox"/> Behavioral / Emotional Disorder | <input type="checkbox"/> Sensory Impaired (hearing, sight, etc.) |
| <input type="checkbox"/> Gifted and Talented | <input type="checkbox"/> Remedial Reading or Math (Title 1) |
| <input type="checkbox"/> Educable Mentally Handicapped | <input type="checkbox"/> Autistic |
| <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Medical or Psychological Disability |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Other condition _____ |
| <input type="checkbox"/> Traumatic Brain Injury | |
| <input type="checkbox"/> Intellectual Disability/ Mental Retardation | |

Does this student presently receive special education services which require an Individual Education Plan (IEP)?

yes no

If yes, describe and provide a copy of current IEP: _____

Does this student have a physical / mental impairment under a 504 plan?

yes no

If yes, describe: _____

Does this student receive other special services (remedial reading, frequent counseling, etc.)?

yes no

If yes, describe: _____

NOTE: Complete Special Services information sheet if student has an IEP or 504

Additional Information

Is student residing with both biological parents? yes no

If no, please provide the following information:

- One biological or adoptive parent
 - A. Provide proof of custody (if divorced)
 - B. Please write the name of the non-custodial parent on line provided below.

- Foster Parent (s)
 - A. Provide appropriate documents
 - B. Provide name(s) of parents and school district they reside in
 - C; Provide name and phone number of social worker:
Case Worker: _____
Phone# _____

- Legal Guardian
 - A. Provide notarized copy of guardianship documents and completed request for Residency Status
 - B. Provide the name(s) of parent on line provided below

- Emancipated Minor
 - A. Provide appropriate documents

Court order (Ex parte) in place: yes no Against: _____

Court order (Child Protection order) in place: yes no Against: _____

Dismissal Information

Child Care Provider Name: _____

Circle one: Baby Sitter Day Care Latch Key Other _____

Child Care Provider Address: _____

Child Care Provider Phone Number: _____

Student Vehicle Information

If your student is a licensed driver and will be transporting themselves to and from school, please provide the following information.

Car Make: _____ Car Model: _____ Car Year: _____

Car Make: _____ License Plate Number: _____

Early Dismissal Procedures

There are times throughout the school year when it becomes necessary to dismiss school earlier than the normal dismissal time. This may be for inclement weather or heat problems. Radio stations KWRE (730 AM) and KFAV (99.9 FM) in Warrenton, are notified on school dismissals. These stations will broadcast school closings and the dismissal time. PLEASE LISTEN FOR THESE BROADCASTS DURING INCLEMENT WEATHER.

Thank you for helping in minimizing the difficulties encountered during these unplanned events.

IF SCHOOL DISMISSES EARLY _____ SHOULD:

Check one:

- Follow normal routine
- Specific instructions (DO NOT specify "use School phone")

Parent/ Guardian Signature: _____ **Date:** ____/____/____

By signing this document you agree that all information that you provided is true and accurate to the best of your knowledge.

Parent/Guardian Signature

Date

STUDENT TRANSPORTATION ENROLLMENT RECORD

Start Date: _____

Parent Name: _____
(Mother) _____ (Father) _____
Cell Phone #: _____ Cell Phone #: _____
Address: _____ Phone #: _____

Student Name: _____ Grade: _____ School: _____ Bus: _____

Student Name: _____ Grade: _____ School: _____ Bus: _____

Student Name: _____ Grade: _____ School: _____ Bus: _____

Student Name: _____ Grade: _____ School: _____ Bus: _____

Student Name: _____ Grade: _____ School: _____ Bus: _____

Student Name: _____ Grade: _____ School: _____ Bus: _____

Name of Road or Highway your residence joins: _____

Give a location or description of where you live. This is important information in locating bus stops.

Additional Information

Alternate Address #1: _____

Contact Person: _____

Home #: _____ Cell #: _____

Check One: Sitter: _____ Friend: _____ Daycare: _____

Bus #: _____ Student (s) this will affect: _____

List days of the week this will occur: _____

Alternate address #2: _____

Contact Person: _____

Home #: _____ Cell #: _____

Check One: Sitter: _____ Friend: _____ Daycare: _____

Bus #: _____ Student (s) this will affect: _____

List days of the week this will occur: _____

FOR OFFICE USE ONLY

Data Entry Completed by: _____

Date Completed and Emailed to Transportation: ____/____/____

Appropriate Paperwork sent to other schools: DB WR RB BHMS WHS

Date Transportation Received and Emailed to Offices: ____/____/____

School Year: _____

Student Name: _____

**Warren County R-III School District
MEDICATION POLICY**

Prescription medication will be given by school personnel. Medication must have a pharmaceutical label stating (1) child's name, (2) name of medication and instruction as to dosage, time, etc. (3) name of doctor prescribing medication and, (4) a current date. Medications will only be administered as stated on the prescription label.

Parents may not send medicine with their child to school. It is the responsibility of the parent or legal guardian to bring the medicine to school.

It should not be necessary to give more than one dose of medication per day during a six-hour school day. Most medication schedules can be arranged so that all doses of medication are taken at home. Exceptions can be arranged with the school nurse.

Students who require emergency medication should have their medication properly labeled as described above. Specific written instruction needs to be provided as to when and under what circumstances medication is to be given. This information will be provided and signed by the student's physician annually.

The district may administer over-the-counter medication to a student upon receipt of a written request and permission to do so by a parent/guardian. The district will provide Advil or generic substitute, Tylenol or generic substitute, upon written permission from parent/guardian up to six (6) doses per semester for students in Kindergarten through 5th grade and up to twelve (12) doses per semester for students in 6th through 12th grades. Further dosage will only occur with written doctor's permission. Please note that the summer school dosage is only up to four (4) doses during the complete summer school period for all students.

Please check the following over-the-counter medication(s) the district is authorized to distribute to your student:

- Acetaminophen (generic Tylenol—provided by district) (Dosage by weight)
- Ibuprofen (generic Advil—provided by district) (Dosage by weight)
- Antacid (generic Tums —provided by district) (Dosage by weight)
- Cough Drops (generic—provided by district) (Dosage by weight)
- DO NOT GIVE

Student Name: _____ Grade: _____

Signature of Parent/Guardian Date

MEDICATION AUTHORIZATION FORM

I request that the nurse or designated school staff member give:

Name of prescribed medication _____ Exact dosage _____ at _____ (time)
Medication to be given from _____ to _____ or as needed _____
Condition for which medication is prescribed: _____
Precautions, possible adverse reaction and interventions: _____

Name of prescribed medication _____ Exact dosage _____ at _____ (time)
Medication to be given from _____ to _____ or as needed _____
Condition for which medication is prescribed: _____
Precautions, possible adverse reaction and interventions: _____

Name of prescribed medication _____ Exact dosage _____ at _____ (time)
Medication to be given from _____ to _____ or as needed _____
Condition for which medication is prescribed: _____
Precautions, possible adverse reaction and interventions: _____

I give my permission for reciprocal exchange of information from Dr. _____ to the Warren County R-III Schools regarding my child. All information received is strictly confidential.

****ALL AUTHORIZATIONS EXPIRE AT THE END OF THE SCHOOL YEAR (INCLUDES SUMMER SCHOOL)****

Parent/Guardian Signature Date

Physician's Signature Phone Number

Please complete this form and return with properly labeled medication(s) to the School Nurse's Office.

Warren County R-III School District

Health Information Sheet (*This form will be updated yearly)

FOR OFFICE USE ONLY:

DBE WRE RBE BHMS WHS

Date: ___/___/___

Student's Full name: _____ Grade: _____

First Middle Last

Gender: M F Date of Birth ___/___/___

Medical:

Physician: _____ Phone #: _____

Date of student's last physical exam: ___/___/___

List previous accidents, surgeries, etc. with dates: _____

Insurance Information:

Does the student have medical insurance coverage? Yes No Don't Know

Name of Provider: _____

Does Medicaid (Mo HealthNet) insure the student? Yes No Don't Know

Student's Birth History: Normal Premature

Complications/ Congenital defects: _____

Please check all that apply, include approximate date:

Student has had:

Student often has:

- _____ Chicken Pox
- _____ German Measles
- _____ Hepatitis
- _____ Measles
- _____ Poliomyelitis
- _____ Rheumatic Fever
- _____ Scarlet Fever
- _____ Whooping Cough
- _____ Meningitis

- Fever (over 105 for ___ days)
- Headache
- Colds
- Sore Throat
- Ear Aches
- Tires easily
- Skin problems
- Joint Pain
- Fainting Spells
- Sleep Walking

- Bathroom Accidents
- Stomach Aches
- Nose Bleeds
- Poor appetite
- Other _____

Student has now (or) has had:

- _____ Artificial Limb
- _____ Bone/Muscle Disease
- _____ Cystic Fibrosis
- _____ Depression
- _____ Heart Disease/Condition
- _____ Muscular Dystrophy
- _____ Physical Disability
- _____ ADD/ADHD
- _____ Bleeding disorder
- _____ Cancer
- _____ Deformity
- _____ Emotional/ Stress-related problems
- _____ Multiple Sclerosis
- _____ Overweight or Underweight for age

Takes medication

Name of Medication(s): _____

Asthma Takes medication

Name of Medication(s): _____

Student has now (or) has had: (continued)

_____ Seizure disorder Takes medication
Name of Medication(s): _____

_____ Diabetes Diet Controlled Takes Medication
Name of Medication(s): _____

Medication:

Does your student take any medication(s)? Yes No

Name of Medication(s): _____

Purpose: _____

Will medication be needed at school? Yes* No

***If the answer to any of these questions is yes, please call to schedule a time to meet with the school nurse**

Life-Threatening Conditions:

Does the student have a life-threatening health condition? Yes* No

Describe: _____

Allergies:

- Plants Animals Food Molds
- Drugs Bees Other

Please describe the allergic reaction and the treatment for each checked allergy: _____

Do you plan for your student to receive school prepared meals? Yes No

Will your student require food substitutions? Yes** No

** The Medical Statement for Student Requiring Special Meals form must be completed to allow food substitutions.

Hearing/Vision Problems:

Does your student wear hearing aids? Yes No

Does your student wear glasses or contacts? Yes No

Physical problem(s) that may limit physical activity: _____

****A COPY OF IMMUNIZATION RECORDS IS REQUIRED AT TIME OF SCHOOL REGISTRATION****

PLEASE KEEP THE SCHOOL NURSE UPDATED AS YOUR STUDENT RECEIVES REQUIRED IMMUNIZATIONS

PLEASE KEEP THE SCHOOL NURSE UPDATED IF YOUR CHILD'S MEDICATION CHANGES

I understand the information given above will be shared with appropriate school staff for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/ Guardian Signature: _____ **Date:** ___/___/___