Student Information

Date: ____________

Father's Name: ______________________ Guardian: ____________________

Mother's Name: ____________________ Mail to: _____________________

Home Address: ____

Street Address: __________________ City: ___________ State: _____ Zip : _______

Telephone Number: ___________________

Father's Employment: __________________________ Phone: __________________

Mother's Employment: _________________________ Phone: __________________

Mother's Cell Phone: __________________

Father's Cell Phone: ___________________

1 Emergency Contact: __________________________Phone: __________________

2 Emergency Contact: __________________________Phone: __________________

Physician: ________________ Phone: _________________

Medication: _____________________

Student's first language: __________________ Home Communication: _____________

Language spoken at home: _______________________________

Ethnicity (please check): Non-Hispanic_____ Hispanic_____

Race (please check all applicable): Native Hawaiian ____ Pacific Islander____ White____

Samoan____ Vietnamese____ American Indian____ Alaskan National____

Last School attended (if not Sublette): ________________________

Grade: _________ Services- IEP: ______ Services- Mig: ______ Biling: _______

Chapter read/math: __________

Student Information

Date: ____________

Student's first name: _________________ **Last name:** __________________

D.O.B.: ______________ **Social Security Number:** _________________________

Grade: ______ **Language:** ___________ **Sex:** _____

Where was the student born? (Please circle one)

United States Mexico Other: ______________

- -

Student's first name: _________________ **Last name:** __________________

D.O.B.: ______________ **Social Security Number:** _________________________

Grade: ______ **Language:** ___________ **Sex:** _____

Where was the student born? (Please circle one)

United States Mexico Other: ______________

- -

Student's first name: _________________ **Last name:** __________________

D.O.B.: ______________ **Social Security Number:** _________________________

Grade: ______ **Language:** ___________ **Sex:** _____

Where was the student born? (Please circle one)

United States Mexico Other: ______________

- -

Student's first name: _________________ **Last name:** __________________

D.O.B.: ______________ **Social Security Number:** _________________________

Grade: ______ Language: ___________ Sex: _____

Where was the student born? (Please circle one)

United States Mexico Other: ______________

Confidential Child Health Record (To be released only on signature of parent/guardian.)

HEALTH ASSESSMENT FOR CHILDREN AND YOUTH

Statement of Consent:

In order to better serve the health needs of my child, I hereby give my permission for the transfer of health screening records to school and other appropriate health professionals.

______________________________ Parent or guardian ________ Date

Name: ______________________ Birth date: ____________ Male/Female: ________

Address: ______________________ City: ______________________

______________________ Zip: ____________

Parent/Guardian: ______________________ Phone/Work: ____________ Home: ____________

Child lives with: ______________________ Phone/Work: ____________ Home: ____________

Number in household: ______________________ Type of family housing: ______________________

Physician: ______________________ Date of last examination: ______________________

Dentist: ______________________ Date of last examination: ______________________

Eye Doctor: ______________________ Date of last examination: ______________________

School: ______________________ Community Services: ______________________

FAMILY HEALTH HISTORY

Response Codes: M = Maternal P = Paternal S =Sibling NA = Not applicable.

Question	Code	Comment
1. Are there any chronic illness problems in your family such as heart disease, diabetes, cancer, convulsions, mental illness, substance abuse, or others? Comment?		
2. Does any family member have a vision defect, hearing loss, or spinal deformity? Comment?		

CHILD/ADOLESCENT HISTORY

Response Codes: Y = Yes N = No NA = Not applicable.

Question	Code	Comment
1. Birth weight ________. Were there any pre-natal or delivery problems with the child?		
2. Did this child walk, talk, and develop at the usual time?		
3. Does this child/adolescent:		
a. See a health care provider regularly?		
b. Use any medication, drugs, or alcohol?		
c. Have a history of any hospitalizations, surgeries or emergency room visits?		
d. Have a history of any childhood diseases/illnesses?		
e. Have a history of other communicable diseases?		
f. Age of menarche __________. Have a history of menstrual problems?		
g. Have a history of vision, speech, hearing or communication problems?		
h. Have a problem with being tired or overactive?		
i. Have any emotional or behavioral problems?		
j. Need any special help in school or day care?		
k. Have sexuality concerns?		
l. Have any chronic illness or disabling problems with (check those that apply):		

Headache _____ Convulsions _____ Diabetes _____ Ear aches _____ Back/spine/extremity problems

Cold/sore throat _____ Rheumatic fever _____ Genitalia _____ Oral/dental _____ ______________

Heart/lung disease_____ Allergies/asthma _____ Digestive _____ Urinary/bowel_____ Other: ______________

List present concerns of child/parent/guardian:

Immunization: Record **date** of each dose received (mm/dd/yy)

	1st	2nd	3rd	4th	5th	6th		1st	2nd	3rd
DPT							MMR			
Td/DT							HBV			
OPV or IPV										
HIB										

PHYSICAL EXAMINATION: To be completed by health care provider approved to perform health assessments.

Height: ____________ Weight: ____________ Hgb or Hct: ____________
Pulse: ____________ Blood Pressure: ____________ Lead ____________
Urinalysis: ____________ Sickle Cell: ____________ Other ____________
Tuberculosis: ____________ Head Circumference: ____________

Code each item as follows: 0 = No significant findings 1 = significant findings	Code	Description of Findings
General appearance		
Integument		
Head - neck		
EENT		
Oral - dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		
Neurological		

SCREENING

1. Nutritional evaluation (all ages - each screen) (• if applicable). Nutrition/WIC questionnaires available from 785-296-0092.
   - Enrolled in WIC
   - Receiving vitamin supplement with iron
   - Without iron
   - Fluoride supplement

   Food intake review. Results:
   milk/milk products (breast fed/type of formula) ____________
   fruit/vegetables ____________
   Meat, beans, eggs ____________
   breads, cereals ____________
2. Development: Type of screen ____________ Results: ____________
3. Speech: Type of screen ____________ Results: ____________
4. Hearing: Type of screen ____________ Results: ____________ Date last screen: ____________
5. Vision: Type of screen ____________ Results: ____________ Date last screen: ____________

Significant assessment findings:

Recommendations (include referrals):

Follow Up:

Additional information may be attached

Anticipatory Guidance (circle those discussed)

1. Safety/poisons
2. Nutrition
3. Parenting
4. Family planning
5. Discipline
6. Immunizations
7. Hygiene
8. Lifestyle
9. Development
10. Behavior
11. Sexuality
12. Dental
13. Other

Comments:

____________ Date

____________ Signature of physician or nurse approved to perform health assessments

UNIFIED SCHOOL DISTRICT NO. 374

Consent For Emergency Treatment And Medical Records

I, the undersigned, being the natural parent (or legal guardian) of

__________________, ________________, ________________,

__________________, ________________, a minor, do hereby consent to the securing of emergency medical treatment for said children by the superintendent of schools of USD 374, Haskell County, or his/her designee, including the necessary transportation to receive such treatment.

I give permission for the exchange of information between the school nurse or other school representative and the student's medical provider. I also give permission for the school nurse or other school representative to copy and send this student's immunization records to schools, physician's offices, and health departments as needed.

Dated this _____ day of ________________________, 20____, and valid until withdrawl from the school district, until specifically revoked, or change of guardianship.

____

(Parent or Legal Guardian)

Witnessed by:________________________

____

Sublette Grade School
Health Enrollment

Student's Name: ______________________________ **DOB:** ___________
SSN: _____-_____-_____ **Sex:** Male ____ Female ____

Address: ____________________ **City/State:** ____________________________
Zip Code: _______

Father's Name: ____________________ **Work Phone** ( )______-______
Mother's Name: ____________________ **Work Phone** ( )______-______
Home Phone ( ) _____-_____

Insurance Information:
Company Name: ____
Phone No.: ______________________ **Group No.:** ______________________

Student's Grade this Year: _____ **Teacher:** ____________________________
Room No.: ______

Medical Alert (allergies, seizures, hypoglycemic, etc.) :

1. ____
2. ____
3. ____

Contacts (who to call in case of emergency with priority designated):

1. ____
2. ____
3. ____

Ethnicity (please check):
Non-Hispanic ____ Hispanic ____

Race (please check all applicable):
Native Hawaiian ____ Pacific Islander ____ White ____ Samoan ____
Vietnamese ____ American Indian ____ Alaskan National ____

Immunization Record:

Vaccine	Due Now/Current	Due Next/Complete	Dose Given
DTaP	______	______	______
Hep B	______	______	______
Hib	______	______	______
MMR	______	______	______
Polio	______	______	______
TB Booseter	______	______	______
Varicella	______	______	______
PCV-7	______	______	______

Family History (parents, grandparents, siblings):

	Relationship	Illness/Disease/Symptoms
1.	______	______
2.	______	______
3.	______	______

Medical Information (please list any current illness, disease, or conditions requiring medical attention):

1. ______
2. ______
3. ______

Assistive Devices (please list glasses, contact, etc. used by child):

1. ______
2. ______
3. ______

Special Problems (eye strain, difficulty breathing, etc.):

1. ______
2. ______
3. ______

Organizations (please list pharmacy used for prescriptions, family Doctor, name of clinic visited):

Pharmacy ______ Doctor ______

Clinic Site ______ Other ______

Prescriptions to be given by School Nurse (please list):

1. ______
2. ______
3. ______

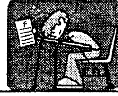
Sublette Elementary School
USD 374

________________________ had Chicken Pox (Varicella).
(Name of student)

____
Date of disease

____
Parent/Guardian Signature   Date

Unified School District # 374
Sublette, Kansas 67877
HOME LANGUAGE SURVEY
GRADES K-12



TO BE FILLED OUT BY PARENT/GUARDIAN:

What language did your child began to speak first? ☐ *English* ☐*Spanish* ☐*German*

What language(s) is spoken in your home? ☐*English* ☐*Spanish* ☐*German*

What language(s) does your child speak? ☐*English* ☐*Spanish* ☐*German*

¿Cual idioma aprendió su hijo/a hablar primero? ☐*Ingles* ☐*Español* ☐*Alemán*

¿Cual es el idioma(s) que hablan en su hogar? ☐*Ingles* ☐*Español* ☐*Alemán*

¿Cual es el idioma(s) que habla su hijo/a(s)? ☐*Ingles* ☐*Español* ☐*Alemán*

¿Necesita intérprete para las conferencias? ☐*Si* ☐*No*

¿Quiere la información de la escuela en español? ☐*Si* ☐*No*

Welche sprache lhren kindafang gemacht hat, zuerst su sprechen? ☐*Englisch* ☐*Spanisch* ☐*Deutsch*

Welche sprache wird in euer heim an meisten gesprachen? ☐*Englisch* ☐*Spanisch* ☐*Deutsch*

Welche sprache redet euer kind an mersten? ☐*Englisch* ☐*Spanisch* ☐*Deutsch*

Felht dir eine person was deutsch redet fuer die eltern? ☐*Ja* ☐*Nein*

Willst du die briefe im deutschen gesardt haben? ☐*Ja* ☐*Nein*

Student(s) Name(s):	**Grade:**	**Language(s):**
1. ______________________	________	______________________
2. ______________________	________	______________________
3. ______________________	________	______________________
4. ______________________	________	______________________
5. ______________________	________	______________________
6. ______________________	________	______________________

Signature/Firma/Unterschrift

Date/Fecha/Datum

SUBLETTE USD 374

Dear Parent:

Please complete the following information to help us to determine if your child/children qualify for the migrant program. This program provides extra academic helps for students who may need assistance as well as other benefits. Thank you for your help.

---

1. Have you moved into this district within the past 3 years? [ ] yes [ ] no
(Note: If you answered "no" to the above question, you do not have to answer any additional questions.)

2. Are you now working in or looking for agricultural work? [ ] yes [ ] no

3. Were you employed in an agriculturally related job in another state or district in Kansas within the last 3 years? [ ] yes [ ] no

---

Parent/Guardian Names	**Present Job**	**Last Employment**
Father:____________	____________	____________
Mother:____________	____________	____________
Children:____________	____________	Grade/Age:____________
____________	____________	____________
____________	____________	____________

Address:____________ Telephone:____________ ____________

________________________ ________________________

Signature of Parent or Guardian Date

Sublette USD 374

Estimados Padres:

Por favor complete la siguiente información para que nos ayude a determinar si su hijo/a califica para el programa emigrante. Este programa prevé ayuda académica extra para estudiantes que necesiten asistencia al igual que otros beneficios. Gracias por su ayuda.

---

1. ¿Se ha cambiado a este distrito escolar durante los últimos 3 años? [ ] si [ ] no
(Note: Si contesto que "no" a la pregunta de arriba, no necesita contestar las demás preguntas.)

2. ¿Esta ahora trabajando o buscando trabajo de agricultura? [ ] si [ ] no

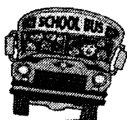
3. ¿Ha estado empleado en algún trabajo relacionado con agricultura en otro estado o distrito en Kansas durante los últimos 3 años? [ ] si [ ] no

---

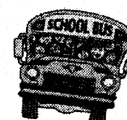
Nombres de Padres/Guardianes	**Trabajo Presente**	**Ultimo Trabajo**
Padre: ______________	______________	______________
Madre: ______________	______________	______________
Hijos/as: ______________	______________	Grado/Edad: ______________
______________	______________	______________
______________	______________	______________
Domicilio: ______________	Teléfono: ______________	______________

____
Firma de Padres o Guardianes

____
Fecha



Transportation 2009-2010



Family's Last Name: ____________________

Children's Names: ____________________

Do you live in town or in the country? Town: ☐ Country: ☐

If you live in the country what is your physical address:

____

Phone Numbers

	Home	Cell Phone	Work	Other	Other
Mother:					
Father:					

Nearest Neighbors:	Home	Cell Phone	Work

Directions to your home from Sublette:

____

____

____

____

Will your student(s) ride the bus? Yes: ☐ No: ☐

If no one is at home when we arrive to drop off your child(ren) after school, what do you want the driver to do?

☐ Drop your child off anyway.
☐ Take my child back to the school and continue trying to call me.
☐ Other: ____________________

<u>Mud Routes</u>

Some parents elect to have their child(ren) walk home from their mud route stop. Do you want us to allow your child to:

☐ Walk home from the mud stop.
☐ Take my child back to the school and continue trying to call me.
☐ Other: ____________________

____________________ Parent Signature ____________ Date