Elementary School Returning Student Registration Packet

Note: A child nutrition and enrollment fee packet will be mailed out 4 weeks before the start of school. Enrollment is not finalized until the fee packet has been turned in.

1. Census Verification Report: This year all returning students are being provided a pre-filled verification form. Please cross out and/or fill in as necessary with the most current information.
   
   A. Student Demographic Information: The state of Kansas requires that you must provide your child’s Legal Name as shown on the birth certificate or adoption papers.
   
   B. Race/Ethnicity Information: This is required by the federal government. Please verify this information is correct.
   
   C. Household Contact Information: We request both a mailing address and a household address if it is different than the mailing address. It is essential that we have a household and a work phone number to locate a parent in case of an injury or emergency. Cell phone numbers are also very helpful.
   
   D. Relationship Contact Information: Please update and/or add non-household members who are emergency contacts for your students. Please list someone who is LOCAL that we can contact in case of an emergency. Be sure to use the FULL names of the emergency contacts. Cell phone numbers and work numbers are helpful.

2. Census Verification Form – EN4: Please provide current employment information. If either parent is active duty military, please make sure to include rank (E-3, O-1, etc.), unit information (A Company, 101st, etc.), and military ID expiration date. Please answer all the important questions listed.

3. Residency & Employment Questionnaire – ER1: This form addresses the McKinney-Vento Act and Migrant Education Program. It will help determine services that may be available for your student.

4. Student Insurance Letter and Waiver: If you already have health insurance and feel that you are adequately covered, please sign and return the waiver. **By signing the waiver you are indicating you do not wish to purchase the insurance.** If you would like to look at the accident insurance offered by the Student Assurance Incorporation, stop by your school office before the start of school. **Enrollment is complete with either the waiver signed or the purchase of the insurance.**

5. Parent Release of Information: This is a release the district may submit to Medicaid if your child receives certain, specific health related services through the district.

6. Student Transportation Forms – ET1 and ET1a: The Student Transportation Form does not include any private bus contractors. All students that are eligible for bussing need to complete the bus form even if they don’t plan to ride. We request this for state reporting reasons.

7. Pupil Transportation Guidelines: Only the students that live in the listed areas are eligible for bus service. Bus routes are subject to change by the Board of Education.

8. Student Health Information Form – EH1: This form needs to be completed each year for each student, even if they do not have a health concern. **Complete the front and the back of this form.**


FYI: Boys & Girls Club Before and After School Programs / Army School-Age Programs in Your Neighborhood (ASPYN): After school programs are available for students attending the following elementary schools: Eisenhower, Franklin, Grandview, Lincoln, Milford, Sheridan, Spring Valley, Washington, and Westwood. A before school program is offered at Spin City for students at each of those schools except for Milford. For information email jamesrussell@usd475.org or call 785-717-4025.
USD 475 Census Verification – EN4

This information is **required** to complete your student’s Registration Packet.

**Student Name:**

**Student Number:**

### Parent/Guardian Employer and/or Military Information

Please provide current employment information. If either parent is active duty military, please make sure to include rank (E-3, O-1, etc.), unit information (A Company, 101st, etc.), and military expiration date.

<table>
<thead>
<tr>
<th>(Last Name)</th>
<th>(First Name)</th>
<th>(Middle In.)</th>
<th>(Suffix, e.g. Jr. II)</th>
<th>(Relationship to Student)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Employer</td>
<td>Work Phone</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Civilian employed on Fort Riley?  
☐ Yes  ☐ No

Military on Active Duty?  
☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>Branch of Service</th>
<th>Military Unit</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Army, Navy, etc.)</td>
<td>(A Company, 101st, etc.)</td>
<td>(E-3, O-1, etc.)</td>
</tr>
</tbody>
</table>

Military ID expiration date:  
( Please use mm/dd/yyyy format.)

---

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</tr>
</tbody>
</table>

Military ID expiration date:  
( Please use mm/dd/yyyy format.)

---

**Important Questions (Please answer the following questions)**

1. Was this student born in the United States?  
☐ Yes  ☐ No

2. Has this student attended a school outside the United States in the past 3 years? (excluding DOD schools)  
☐ Yes  ☐ No

3. What date did this student Enter the US?  

4. What date did this student enter a US School?  

5. Does this student have an Individual Education Plan (IEP)?  
☐ Yes  ☐ No

6. Has this student been involved in a program for Gifted/Talented through school?  
☐ Yes  ☐ No

7. Does this student have a 504 Plan?  
☐ Yes  ☐ No

---

**For Office Use Only**

Teacher:  
Lunch Code:  
Student Number:  
Building:  
Start Date:  
School Fees:  
Bus Route:  
Sec8003:  

---

******************************************

For Office Use Only

******************************************
USD 475 Student Information Form – ER1

The answers to this document, which addresses the McKinney-Vento Act and Migrant Education Program, will help determine services that may be available to your student.

Student Name______________________________________________________

School________________________________

Student Grade _____ Date of Birth ____________________ Male ___ Female ___ Military Student? Yes__ No___

Parent/Guardian(s)________________________________________________________________Phone____ ________

Present Address _________________________________________________City ___________________ State____ Zip ______ ___

Last School Attended _____________________________________________City __________________________   State ____ ____

Is your current address a temporary living arrangement? Yes _______ No, I am in stable housing _______

If YES, have you recently lost your housing or experienced an economic hardship? Yes _____ No______

Within the last 3 years, we have done seasonal migratory work. Yes _____ No _____

If you answered YES to any of the above, please COMPLETE THE REMAINDER OF THE FORM.

If you answered YES to any of the above, please COMPLETE THE REMAINDER OF THE FORM.

<table>
<thead>
<tr>
<th>Section A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Living Arrangements</strong> (Must Select One)</td>
</tr>
<tr>
<td>☐ Temporarily with another family (due to loss of job, loss of housing, etc.)</td>
</tr>
<tr>
<td>☐ In a motel/hotel</td>
</tr>
<tr>
<td>☐ In a shelter</td>
</tr>
<tr>
<td>☐ Unsheltered (campgrounds, cars, parks, or other place not designed for permanent housing) or substandard housing</td>
</tr>
</tbody>
</table>

**Independent Living Student** (Check if Applicable)

☐ Alone without parental support (student living independently)

<table>
<thead>
<tr>
<th>Section B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the last 3 years, we have done seasonal migratory work? Yes____ No_____ If Yes, please identify:</td>
</tr>
<tr>
<td>☐ Temporary laborer harvesting crops Location: __________________________________________________________________________</td>
</tr>
<tr>
<td>☐ Temporary farm, poultry or dairy labor Location: ________________________________________________________________________</td>
</tr>
<tr>
<td>☐ Temporary greenhouse or nursery work Location: ________________________________________________________________________</td>
</tr>
</tbody>
</table>

I certify by my signature that the above information is accurate.

Parent/Guardian Signature _____________________________ Date _____________________________

**ATTENTION SCHOOL PERSONNEL:** If Sections A or B are checked, please forward the completed form to Marty Rombold, Lincoln Elementary School, 300 Lincoln Drive, Junction City or fax her attention at (785)717-4571.
Dear Parents,

Student Accident Insurance is available to USD 475 students through Student Assurance Incorporated. Coverage options available are Full-Time (24 hour) accidental injury coverage (with optional Major Expense Benefit), School Time accidental injury coverage and/or Extended Dental Coverage. Although the premiums charged for each coverage for the 2014-2015 school year are not available at this time, premiums for student accident insurance through Student Assurance Incorporated continues as an inexpensive way to provide coverage for your student. If your student does not currently have accidental injury coverage or if your family policy has a high deductible, this coverage might be of interest to you.

If you are interested in obtaining accident insurance coverage for your student, please inform the office staff during enrollment or during the first weeks of school. The information, as well as the enrollment envelopes you will need to fill out, will be available at that time.

If you elect not to enroll your student in the Student Assurance Accident Insurance plan, please sign the “Parental Insurance Waiver” section below and return it, along with your school enrollment paperwork, to the appropriate school. The school office must have a signed Parental Insurance waiver on file for any student who is not enrolling in Student Accident Insurance plan.

Please sign and return the form below to the school if you do not wish to purchase insurance. If you determine at a later date that you would like to purchase insurance, please notify the School Office.

PARENTAL INSURANCE WAIVER

Student’s Name ________________________________  School _______________________________

I, the undersigned, feel I have adequate insurance protection for my son/daughter while participating in school sponsored activities.

Parent’s/Guardian’s Signature ___________________________  Date _________________________

Parent’s Printed Name ____________________________________________
Geary County Schools, USD 475  
Kansas  
Parent Consent for Release of Information and Medicaid Reimbursement

Consent to Release Information:
I consent for Geary County USD 475 to release records or information about my child’s participation in services to participating physicians, other health care providers, the Kansas Department of Health and Environment (KDHE), any KDHE billing agents, and any school billing agent, as necessary, to process claims for reimbursement by KDHE for covered health-related services, evaluations for these services and transportation, on the day the student receives any health-related service, which are outlined in the child’s Individualized Education Program (IEP), including duration and frequency of IEP services.

Consent to Access Public Benefits
- I give consent for the school to access the child’s or parent’s public benefits or insurance to pay for services under 34 C.F.R. part 300.

Procedural Safeguards:
- I understand that the school may be required to provide certain health-related services to a student who has an IEP at no additional cost to the student’s parent(s), and that my refusal to sign this form will not affect whether such services are provided at no cost to the student named above.
- I understand that I will not be required to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services. I understand that my child’s Medicaid benefits will not be used if that use will:
  (a) decrease available lifetime coverage or any other insured benefit; (b) result in your family paying for services that would otherwise be covered by a public benefit or insurance program and that are required for the child outside of the time the child is in school; (c) increase premiums or lead to the discontinuation of benefits of insurance; or (d) risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.
- I also understand that the granting of consent is voluntary and may be withdrawn at any time. If I later revoke consent, that revocation is not retroactive (i.e. it does not negate any action that has occurred after the consent was given and before the consent was revoked).

☐ I give consent for the school to release Education Records or information and to access Public Benefits as described above in order to submit claims to the Kansas Department of Health and Environment (KDHE),

☐ I do not give consent.

__________________________________________  ____________________________  ____________________________
Child’s Name                                Date of Birth                       Begin Date

__________________________________________
Parent/Guardian Signature                    Date

Revised August 2013
# Student Transportation Form – ET1

<table>
<thead>
<tr>
<th>New Request</th>
<th>Returning Rider</th>
<th>Update</th>
</tr>
</thead>
</table>

**Last Name** ______________________ **First Name** ______________________ **Student Number** ______________________

**School** ______________________ **Grade** ________

**Home Street Address** _____________________________________________________________

*DO NOT USE A P.O. BOX NUMBER*

**Parent/Guardian** ________________________________________________________________

**Home Number** ______________________ **Work Number** ______________________ **Cell Number** ______________________

**Work Number** ______________________ **Cell Number** ______________________

**Release Student to**

**Emergency Contacts:**
1. __________________________________________ Phone Number ______________________
2. __________________________________________ Phone Number ______________________

---

## Authorization for Release of Information

(If applicable for busing, complete this section)

**Exceptionality or Disability:** ______________________________________________________

**Health Concerns:** ________________________________________________________________

**Behavioral Issues:** ______________________________________________________________

**Special Equipment:** ______________________________________________________________

*eg., wheel chair, crutches, braces, etc.*

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
</table>

I hereby authorize the use of disclosure of the above named student’s health information as described below. USD 475 is authorized to disclose student health information to any business associate of USD 475 for the purpose of assisting said Business Associate in caring for said student. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign authorization. I understand that any disclosure of information carries with it a potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I have read the above and forgoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. **It is expressly agreed that a photocopy of this authorization shall be considered as valid as the original.**

I acknowledge that both parent/guardian(s) and student(s) are to read the Parent/Student Transportation Handbook and agree to follow its policies, rules and regulations.

**Date** ______________________ **Parent/Guardian Signature** ______________________ **Student Signature – (secondary students)** ______________________

**Requested Start Date** ____________ (It takes two school days once the Bus Barn receives the request for transportation)

---

For Bus Barn use only: **Route #:** ________ **Stop:** ____________________________ **Time of Pick Up:** ________
**Authorization for Release of Information**

If applicable for busing, complete this section

| Exceptionality or Disability: | ______________________ |
| Health Concerns: | ______________________ |
| Behavioral Issues: | ______________________ |
| Special Equipment: (eg., wheel chair, crutches, braces, etc.) | ______________________ |

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---

**Head Start, Early Childhood or Exceptional Education Transportation Only**

An IEP or Section 504 Team must make the decision for special transportation to occur. Indicate Session: AM PM ALL DAY (circle one)

---

**For Bus Barn use only: Route #: Stop: Time of Pick Up:**
**Parents/Guardians:** *This form must be completed each year and returned to the school nurse.*

**Complete Both Sides of this Form**

<table>
<thead>
<tr>
<th>Student Name _______________________________________</th>
<th>Birth Date _____________</th>
<th>Grade _______</th>
<th>Date _______________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Does this student:</th>
<th>Yes</th>
<th>No</th>
<th>Parent/Guardian Comments</th>
<th>Health Room Staff Notations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have a medical diagnosis of a current or chronic health problem (such as diabetes, tuberculosis, seizures, cystic fibrosis, asthma, muscular dystrophy, digestive disorders, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition _______________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician ______________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 2. Receive ongoing medication for conditions (ADHD, allergies, asthma, diabetes, depression, anxiety, etc.) | | | Health forms and medication guidelines available from school nurse or on Health Services page of the USD475.org website |
| Medication ______________________ | Dosage _____________________ | Time Administered _________ | Reason for giving ____________________________ |
| Fill out Medication Permission form if it needs to be taken at school. |

| 3. Known allergies (food, pollen, animals, medicine, etc) | | | |
| ______________________________________________________________________ | | | |
| ______________________________________________________________________ | | | |

| 4. Hearing Concern | | | |
| Known Condition: ______________________ | Wears Hearing Aid: Yes_____ No_____ | Date of last hearing exam: ____________ | |

| 5. Vision Concern | | | |
| Wears glasses/contacts: Yes___ No____ | Date of last eye exam: ____________ | |

| 6. Dental Health | | | |
| Known Concern: ______________________ | Last Dental Appointment: ______________________ | |

| 7. Special instructions for activities, dietary, restroom, etc. | | | Need health care provider order to modify Physical Education requirements |
| ______________________________________________________________________ | | | |
| ______________________________________________________________________ | | | |
Health Emergency Information

Home Phone for Household: ______________________

Mother/Guardian’s Name: ____________________________________________

Mother/Guardian’s Cell Phone: ______________  Mother/Guardian’s Work Phone: ______________

Father/Guardian’s Name: ____________________________________________

Father/Guardian’s Cell Phone: ______________  Father/Guardian’s Work Phone: ______________

Local Emergency Contact: ________________________________

Emergency Contact’s Phone: ______________________

---------Permission/Release Statements---------

I give my consent for my child’s immunization information to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

__________________________  __________________
Signature of Parent/Guardian    Date

I give consent for my child’s immunization information to be shared with/obtained from other schools or health care providers/clinics for the purpose of meeting school health requirements.

__________________________  __________________
Signature of Parent/Guardian    Date

The following information is requested to help provide parents with accurate information about obtaining health care services:

Type of Health Insurance:
  Tri-Care _______  Private _______  None _______
  KanCare (Amerigroup, Sunflower or United Health) _______

Type of Dental Insurance:
  KanCare _______  Private _______  None _______
  MetLife (purchased for military dependents) _______

Student’s Doctor _______________________________________________________

Student’s Dentist _______________________________________________________
DATE:            May 14, 2014

MEMO TO:       Parents/Guardians

FROM:           Ronald P. Walker
               Superintendent of Schools

SUBJECT:        Child Nutrition Reduced Price/Free Application

The following forms will be sent to all households 4 weeks before the start of school.

- Child Nutrition and Fee Assessment
- Application for Child Nutrition Program Benefits (Free and Reduced Lunch)
- Free Textbook Guidelines and Textbook Rental Fees FAQ
- Free Textbook Waiver Form
- Textbook Rental Payment Agreement

If your student has a food allergy, intolerance, or special dietary need that requires modification of the school menu, please pick up the Medical Statement for Student Requiring Special Meals Due to Food Allergy or Intolerance form at your student’s school.