BC_____
SS_____
IM_____

Student Information Sheet

2024-2025

(Please print all information)

Student Information

Legal Name *(L-F-M):* _____

Physical Address: _____

City _____Zip Code _____

Mailing Address *(if different)*: _____

City _____Zip Code _____

Physical Home Phone: _____

Gender:_____ **Grade Level**: _____

Birth date:_____ **Age**: _____

Social Security #:_____

Race *(Circle One)* | African American | American Indian | Asian | Caucasian | Hispanic | Pacific Islander |

Legal Alerts:_____

_____

Student lives with: *(circle one)*
| Mother & Father | Mother & Stepfather | Father & Stepmother |
| Mother Only | Father Only | Foster Home | Other: _____

Student Medical Information

Doctor's Name: _____

Doctor's Phone:_____

Dentist's Name:_____

Dentist's Phone: _____

Special Medical Conditions
(ex. Hearing aid, glasses, medicines, etc):

_____

_____

Allergies: _____

_____

Brothers, names & ages:

_____

_____

Sisters, names & ages:

_____

_____

Male Legal Guardian Information

Name *(Last-First)*: _____

Physical Address *(If different from student):* _____

_____

Day Phone: _____

Employer:_____

Home Phone:_____

Email Address:_____

Female Legal Guardian Information

Name *(Last-First)*: _____

Physical Address: *(If different from student):*_____

_____

Day Phone: _____

Employer:_____

Home Phone:_____

Email Address:_____

Emergency Contact Information

(Other than Legal Guardians)

Contact 1

Contact Name :_____Address:_____

Phone:_____Circle one: | Cell | Home | Work | Relationship_____

Contact 2

Contact Name :_____Address:_____

Phone:_____Circle one: | Cell | Home | Work | Relationship_____

Contact 3

Contact Name :_____Address:_____

Phone:_____Circle one: | Cell | Home | Work | Relationship_____

Guardian's Signature:_____**Student T-Shirt size:**_____ **Date:**_____

Thank you for choosing Community Health Center of Southeast Kansas, Inc. (CHC/SEK) for your child's health care needs. CHC/SEK's school health clinic(s) is available for all students. By completing this form, you are helping CHC/SEK better take care of your child. If you have any questions call 620.240.5061. *Please complete this form in ink.*

PATIENT INFORMATION

Full Legal Name

Last Name:	First:	Middle:

Date of Birth_____ Male ❑ Female ❑ Social Security Number_____

Mailing Address_____ City _____

State & Zip _____ E-Mail Address_____ Phone Number_____

Do you want to access your medical records electronically? ☐ Yes ☐ No
(If yes, you will receive an email, at the email address listed above, from CHC/SEK with your log-in information and the log-in URL.)

Preferred method of communication for appointment reminders: ❑ Text ❑ Phone Call

School Name: _____

Patient Grade Level: _____ School Location (City, State): _____

Race:
❑American Indian/Alaskan
❑Asian
❑Native Hawaiian
❑Black or African American
❑White
❑Pacific Islander
❑Other Race

Ethnicity:
❑Hispanic/Latino
❑Not Hispanic/Latino

Preferred Language
❑English
❑Spanish
❑Other _____

If you are Homeless, are you:
❑On the Street
❑Doubling Up
❑In Transitional Housing
❑In a Shelter
❑Other

Other than CHC/SEK's school health clinic(s), who does the patient use for his/her medical care?
(Check all that apply) ❑CHC/SEK ❑Other:_____ ❑N/A

RESPONSIBLE CAREGIVER

Name_____
Date of Birth _____
Relationship to the Patient_____
Mailing Address _____
City, State, Zip _____
Phone Number _____

Name_____
Date of Birth _____
Relationship to the Patient_____
Mailing Address _____
City, State, Zip _____
Phone Number _____

(If Responsible Caregiver(s) is a foster parent or out-of-home placement, please provide appropriate paperwork illustrating placement and appropriate paperwork illustrating who maintains authority to make medical decisions on the patient's behalf).

Please Complete the Back of Form

EMERGENCY CONTRACT

In the event of an emergency, who should we contact? _____

Relationship to Patient: _____ Phone Number: _____

INSURANCE INFORMATION (Check all that apply)

❑KanCare (Aetna, Sunflower, United HealthCare)
❑ Kansas Farmworker Health Program
❑No Health Insurance (Staff are available to help determine if you are eligible for coverage)
❑Commercial Insurance
❑Medicare
❑ Other Medicaid

Primary Insurance	**Secondary Insurance**
Insurance Plan_____	Insurance Plan_____
Member ID Number _____	Member ID Number _____
Group Number _____	Group Number _____
Policy Holder Information:	**Policy Holder Information:**
Full Name _____	Full Name _____
Date of Birth _____	Date of Birth _____
Social Security Number _____	Social Security Number _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____

Pharmacy: _____ _____
Name City & State

**Apothecare, located in CHC/SEK's Pittsburg, Fort Scott, Pleasanton, Iola, and Columbus clinics, is CHCSEK's preferred pharmacy.

Consent for Treatment and Insurance Billing

Please Read and Sign Below.

I give consent for treatment by Community Health Center of Southeast Kansas, Inc. (CHC/SEK) for medical, dental and/or mental health services. I understand that services are available, regardless of ability to pay and without discrimination. If I am consenting for a minor child, I understand that no treatment will be given without my knowledge or consent unless the treatment relates to an emergency or the treatment is otherwise permitted under applicable federal or state law.

- I understand that if I am consenting to treatment of my child, if a court order has been entered with respect to the conservatorship of said child, or impacting my rights to consent to the child's care and treatment, CHC/SEK will not render services to the child until CHC/SEK has received and reviewed the most recent court order.

- I understand that the information in my health record (if a mature minor) or my child's health record is confidential and will not be released to any unauthorized person or agency without consent.

- I assign to CHC/SEK any and all benefits payable from any insurance provider covering the patient or person responsible for the patient's care to be paid directly to CHC/SEK which will be applied to the charges for services rendered.

- I understand that vision and hearing screenings may be billed to my insurance carrier.

- I understand that CHC/SEK may disclose all or any part of the patient's medical record to any insurance company, corporation or person which is or may be liable under a contract or part of CHC/SEK's charges, including, but not limited to, medical services companies, insurance companies or pharmaceutical manufacturers.

- I authorize CHC/SEK to disclose all or any portion of my health record (if a mature minor) or my child's health record to my health care provider (if a mature minor) or my child's health care provider who is: _____.

- I authorize CHC/SEK to disclose all or any portion of my health record (if a mature minor) or my child's health record to school personnel as it relates to my child's academic success.

- I authorize CHC/SEK to examine my school records (if a mature minor) or my child's school records to assist staff in providing the necessary care for my child.

- If there are services you would like to opt out of, please list them here: _____.

With my signature, I certify that I understand the above and that I am authorized to sign for the patient.

_____
Signature of Patient, Agent, Representative, Parent, Legal Guardian or Responsible Party

_____ _____/_____/_____
Relationship to Patient Date (Month/Day/Year)

Printed Student Name: _____ Student Date of Birth: _____/_____/_____

Form Updated: 01/2021

Health Services

2024-2025 School Year Baxter Springs USD #508

Students Name DOB Grade

Yes	No	
		Attention Deficit Disorder (if YES circle) ADHD ADD Medication:
		Allergies (if YES, circle below and explain) Food Insect bites/Stings Pollen Animals Medication Will your child have an Epi-pen at school? YES NO
		Asthma Will your child have an inhaler at school? YES NO
		Diabetes Medication:
		Emotional Problems Medication &/or Counseling:
		Seizure Disorder Type of Seizure: Medication:
		Other Health Concerns Including Hospitalizations, Operations, or Medications Not Previously Mentioned:

Kansas State Law requires that each student must present to the school:

- An **up to date immunization record** or a religious exemption or medical exemption
- A **physical exam** performed by a licensed healthcare provider
- A copy of an **official state issued birth certificate**

All medications given at school must be provided by the parent and come in a properly labeled original container and **an authorization for medication form** must be filled out and signed by the prescribing provider/doctor.

I hereby certify that I have read and understand the school requirements for my child. Furthermore, permission is hereby granted to the attending team physician, athletic trainer, coach, school nurse, sponsor, and/or teacher to render any necessary first aid treatment to the child listed below. I understand that in an emergency, effort will be made to contact the Parent/Guardian or other contact persons listed. If such contact is not possible, the transportation and treatment necessary for the best interest of the student may be given.

I also authorize USD #508 schools to release, exchange, and obtain immunization and/or health in their possession, relating to the named student, to the Health Department, physician(s), school personnel working with the student, and/or Kansas Immunization Registry. I understand that this authorization will expire when the student is no longer enrolled in the above named school district and that I may revoke this authorization in writing at any time.

_____

Parent/Guardian signature Today's date

For Office Use Only HYG Initials_____ FR_____
Screening #s _____ EXT _____
P / F SEALANT(S) _____
SDF _____ ITR _____
Urgent _____ Teacher _____

EO:3_____14_____19_____30_____

2024-2025 DENTAL Consent Form

Community Health Center of Southeast Kansas will be providing dental treatment at your student's school this year. All children are invited to participate in the program, but the program has a special focus on those children not receiving services elsewhere. No child will be denied services based on insurance status or ability to pay**.** However, INSURANCE (if available) WILL BE BILLED.

School Name_____ **Grade: _____ Parent/Guardian Phone #**_____

Student's LEGAL Name_____ **DOB: _____Gender: _____ Age: _____**

Parent/Guardian Name_____ **Parent/Guardian DOB: _____**

Address_____**City**_____**State**_____**Zip**_____

Student's Race

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Decline to Specify

Student's Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Student's Language ☐ **English** ☐ **Spanish** ☐ **Other** _____

DENTAL INSURANCE

Please complete the insurance section below. **We will bill your insurance for services provided.**

- ☐ KanCare (Aetna, United Health Care, Sunflower) #_____
- ☐ Medicaid (Oklahoma or Missouri) #_____
- ☐ No Insurance
- ☐ Commercial/ Private Insurance

Commercial Insurance Policy Holder Name _____DOB_____ SSN#_____

Insurance Company_____ Policy#_____ Group#_____

As parent or legal guardian of the student named above, I give Community Health Center of Southeast Kansas permission to provide dental services by CHC/SEK clinical professionals as is necessary in their judgement. I understand that no promise, guarantee, or warranty has been made regarding the result of any care provided by CHC/SEK.

This consent is valid for **one year** from the Parent/Guardian Signature date below.

Dental services **MAY** include the following**: Cleaning, Sealant, Fluoride, Silver Diamine Fluoride, Temporary Filling, Injection of Local Anesthesia, Baby Tooth Removal, and Exam *(exam for Head Start locations only).***

**If local anesthesia or the removal of a baby tooth is recommended, you will receive a phone call before continuing treatment.

****Please list any services you do **NOT** want your student to receive _____

Parent/Guardian Signature_____ **Date**_____

Kansas Bureau of Oral Health

Kansas Department of Health and Environment

PLEASE COMPLETE and SIGN SECOND PAGE

DENTAL HEALTH HISTORY FORM
PAGE 2 of 2

Student's First and Last Name_____ DOB_____

When did your student last visit a dentist?

- ○ In the past year
- ○ More than a year
- ○ Never

Why did your student visit the dentist?

- ○ Checkup
- ○ Cleaning
- ○ Pain
- ○ Filling
- ○ Tooth pulled
- ○ Other

Medical History: Please check all that apply

- ○ Heart Murmur
- ○ Artificial Joints/ Pins/Screws
- ○ Seizure Disorder
- ○ Asthma
- ○ Diabetes
- ○ Hepatitis
- ○ Heart Disease
- ○ Congenital Heart Disorder
- ○ Artificial Heart Valve
- ○ Other

Please list all DRUG, FOOD, and other ALLERGIES:

_____

Name of child's medical doctor_____

Is your student required by a physician to take a pre-medication (antibiotics) prior to dental treatment?
If yes, what condition_____

Does your student have special health care needs? If yes, please explain:

_____

Surgeries/ Hospitalizations / Other Medical Conditions:

_____

Please list all medications your student is currently taking:

_____

Please tell us anything you think we should know about your student's health of previous dental experiences that would help us treat or meet their needs_____

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

Parent/ Guardian Signature_____Date_____

BAXTER SPRINGS SCHOOLS, USD 508

1520 Cleveland Avenue ♦ Baxter Springs, KS 66713 ♦ 620-856-2375 ♦ Fax: 620-856-3943

Lincoln Elementary
801 Lincoln Ave
620-856-3322

Central Elementary
1501 Park Ave
620-856-3311

Middle School
104 North Military
620-856-3355

High School
100 North Military
620-856-3366

STUDENT PERMISSION FORM

_____ _____ _____
Student's Name Grade DOB

The student listed above has permission to: **(Initial for consent)**

_____ take part in all school sponsored activities.

_____ allow USD 508 to use my child's name, picture, and/or classroom work on the district's web site, school publications, and to provide the same information to local newspapers and/or television stations.

_____ to participate in any reward programs (Weekly Homework Completion Drawings, AR Reading, etc.)

_____ I do give my permission for information contained on my student's permanent school immunization record to be released to the Kansas Immunization Program for the purpose of assessment and reporting. I also give my permission to share these immunization records with other schools, physicians, or health departments as deemed necessary for my child to be immunization compliant as per Kansas laws.

_____ _____
Parent/Guardian Signature Date

BAXTER SPRINGS USD #508

CUSTODY LAW NOTIFICATION

Custody disputes must be handled by the courts. By law, if parents are legally separated or divorced, each parent has equal rights to the custody of the children *UNLESS* one of them has a signed court order that indicates otherwise. The school has no legal right to refuse biological parent's access to their children and/or school records.

If a parent has a signed, ***current*** court order limiting the other parent, or any other person, the school *MUST HAVE A COPY* of the court order on file. If a copy is not on file, the school is required by law to release children to their parents with proper identification. Situations that put the welfare of students in question will be handled at the discretion of the Principal/designee. In situations that become a disruption to the school, the Baxter Police Department will be contacted, and an officer will be requested to intervene.

Parents are asked to make every attempt not to involve schools in custody matters. Please have current information on file for your children.

Student Name: _____

Parent/Guardian Signature: _____

Date: _____

Acceptable Use Policy
(Computers, Networks, & Internet)

The Internet is a tool for life-long learning. It is a necessary tool for Baxter Springs Public Schools to develop students ready to live and work in the 21st Century.

With the privilege of Internet access comes responsibility and accountability. Baxter Springs Public Schools expects that all students using the District network and the Internet services it provides will:

1. Have the permission of their parent or guardian.
2. Agree to abide by the policies and responsible use set forth in the Baxter Springs Public Schools Acceptable Use Policy.
3. Understand the use of the District network and Internet services is a privilege which may be terminated by the school or district for failing to abide by the policies described in the Acceptable Use Policy.

As the parent or guardian of a Baxter Springs Public Schools student we are asking that you review the policy and guidelines set in this Acceptable Use Policy and that you go over the Acceptable Use Policy with your child so that everyone understands and is in agreement.

Privacy is not guaranteed

The Superintendent, principals, and other administrators may review files and monitor all student computer and Internet activity to maintain system integrity and ensure that users are acting responsibility. Teachers and administrators may monitor ongoing student Internet activity to maintain system integrity and ensure that student users are abiding by this policy and are acting responsibly. Privacy is not guaranteed. Electronic messages and files stored on school-based computers may be treated like school lockers.

Use is a Privilege

Use of the network and the Internet is a privilege, not a right. Students violating policies pertaining to standards of conduct or network/Internet use shall be subject to revocation of privileges and potential disciplinary and/or appropriate legal action.

Liability

Baxter Springs Public Schools makes no assurances of any kind, whether expressed or implied, regarding any Internet services provided. The school district will not be responsible for any damages the user suffers. Use of any information obtained via the Internet is at the user's own risk. The school district will not be responsible for any damages users suffer, including -- but not limited to -- loss of data resulting from delays or interruptions in service. The school district will not be responsible for the accuracy, nature, or quality of information stored on school district diskettes, hard drives, or servers; nor for the accuracy, nature or quality of information gathered through school district provided Internet access. The school district will not be responsible for personal property used to access school district computers or network for school district-provided Internet access. The school district will not be responsible for unauthorized financial obligations resulting from school district-provided access to the Internet.

Parental Advisory

The global and changing nature of the Internet network's contents make it extremely difficult for the school district to completely regulate and monitor the information received or sent by students. As such, the school district cannot assure parents that students will be denied access to undesirable materials or sending or receiving objectionable communications. Parents and guardians of students should be aware that some material accessible via the Internet may contain items that are illegal, defamatory, inaccurate, or potentially offensive to some people. In addition, it is possible to purchase certain goods and services via the Internet, which could result in unwanted financial obligations for which a student's parent or guardian would be liable. While the school district's intent is to make Internet access available in order to further educational goals and objectives, students may find ways to access other materials as well.

Acceptable Use

The educational value of student Internet access is the joint responsibility of students, teachers, parents and employees of Baxter Springs Public Schools. Since access to the Internet is a valuable and limited resource, students are expected to place a premium on the quality of use. Taking up valuable network resources to pursue frivolous ends, not consistent with the mission of Baxter Springs Public Schools is prohibited. **All use must be consistent with the educational mission and goals of the school district.**

Unacceptable Use for Student Users

- Users shall not use school district computers or networks for purposes of personal profit, any non-instructional, or non- administrative purpose (e.g., activities for personal profit).
- Users shall not use a computer for unlawful purposes, such as the illegal copying or installation of software, or violation of copyright laws.
- Users shall not erase, rename, or make unusable anyone else's computer files, programs or disks.
- Accessing another person's materials, information, or files without the implied or direct permission of that person is prohibited.
- Users shall not use or try to discover another user's password.
- Users shall not copy, change or transfer any software or documentation provided by the school district, teachers, or another student without permission from the superintendent or his designee.
- Users shall not write, produce, generate, copy, propagate, or attempt to introduce any computer code designed to self-replicate, damage, or otherwise hinder the performance of any computer's memory, file system, or software. Such software is often called a bug, virus, worm, Trojan Horse, or similar name.
- Users shall not deliberately use the computer to annoy or harass others with language, images, or threats.
- Users shall not deliberately access or create any obscene or objectionable information, language or images.
- Users shall not intentionally damage the system, damage information belonging to others, misuse system resources, or allow others to misuse system resources.
- Users shall not tamper with computers, networks, printers or other associated equipment except as directed by the teacher or the superintendent or his designee.
- Users shall not take home technology equipment (hardware or software) without permission of the supervisor.
- Users shall not gain unauthorized access to resources or entities.
- Users shall not invade the privacy of individuals.
- Users shall not post anonymous messages.
- Users shall not use the network for commercial or private advertising. The Internet, web pages, and other technology shall not be used for private or commercial offerings of products or services for sale, or to solicit products or services or to raise funds for non-district related activities or organizations.
- Users shall not use the network while access privileges are suspended or revoked.
- Users shall report illegal or unauthorized use of the network to the supervising teacher or the authorized technical and information services administrator.

Student Internet Access Return Form

Fill out the statement below and return it to your child's school if you wish to allow your child access to the Internet at school. If you do not return this form, the school will assume that you do not give your permission for Internet access to your student.

I request that my child be allowed to have Internet access at school. I have read and understand the Baxter Springs Public Schools Acceptable Use Policy. This authorization will expire when the student is no longer enrolled in their current school.

_____	_____
Student Name (Print)	**Parent Name (Print)**
_____	_____
Student Signature	**Parent Signature**

(Authorized faculty designee will retain this form on file for the duration of applicable computer/network/Internet use.)

Baxter Springs, Kansas
Parent & Student Learning Compact

Student _____ Date_____

School _____

This Learning Compact is a way for the school and the parents to become equal partners in student learning.

The school will do the following.

- Provide education activities that are appropriate for your child.
- Provide communication to parents concerning your child.
- Procide necessary assistance to parents so they can hep their child.
- Have high expectations for student achievement.
- Provide a safe and encouraging learning environment.
- Make learning as enjoyable and relevant as possible.
- Make use of all supposrt services and materials available.
- Assign relevant and useful homework.
- Show respect for each child.

Signature _____

As a student I will do the following. (optional)

- Attend school regularly.
- Work Hard to do the best I can in class.
- Respect and cooperate with other students and adults.
- Ask for help when I need it.
- Complete and return homework.
- Help keep my school safe.
- Follow school rules.

Signature _____

As a parent I will do the following.

- Attend parent-teacher conferences.
- Make sure my child has their physical and emotional needs met.
- Encourage my child to do their best in school.
- Talk to my child and show interest in what they are doing in school.
- Provide a quiet place for study in my home.
- Make sure my child does assigned homework and provide support when needed.

Signature _____

BAXTER SPRINGS PUBLIC SCHOOLS
Enrollment Residency Questionnaire
For Homeless

This form is intended to address the McKinney-Vento Act. Your answers will help determine residency documents and certain needs for the student. Please fill out. If none of the choices in Section "A" apply then check the box in Section "B" and you do not have to provide any further information.

Presently, where is the *student* living? (Check one)

Section A	Section B
☐ In a shelter_____ Shelter Name ☐ *Temporarily* with more than one family (due to loss of job, loss of housing, etc.) ☐ In a motel, car, or campsite ☐ In a temporary foster care awaiting permanent placement ☐ Alone without parental support (independent living Student) **CONTINUE**: If you checked a box in this section, please *complete the rest of this form*.	☐ Choices in Section A do NOT apply. **STOP:** If you checked this section, you do *not* need to complete the remainder of this form.

Student Name_____ Date of Birth _____

School_____ Grade _____ Male ☐ Female ☐

Parent/Guardian(s)_____

Present Address _____

City _____ State ____ Zip _____ Phone _____

Last School Attended _____ City_____ State ____

THIS AREA FOR STAFF USE:

At time of enrollment, please check off documents that are presented: Date Enrolled:
__Address Verification __Birth Certificate __Immunization __Previous School Records

*****Please admit student immediately while documentation is being obtained*****

If **Section A** is checked:
Instructions for Office Staff – Make a copy of the completed form. Send it via interschool mail to the Homeless Education Coordinator. The homeless liaison will notify Nutrition Services regarding meal status. (Meal Application not needed – only the Waiver of Confidentiality needs to be filled out for these families.)

Kansas Migrant Education Program

Identification & Recruitment
Parent Survey

Parent's name_____ Date_____

Address_____

Telephone number_____

Has your family moved in the last 3 years? ☐ Yes ☐ No

How long has your family lived at your present address? ____years ____months

Previous address_____

Has anyone in your family worked in anything related to the jobs listed below? ☐ Yes ☐ No

Feed Cattle, Processing, Packing

Dairy

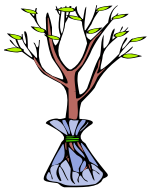
Eggs

Cultivation, Preparation of soil

Fishing

Harvest (fruit and vegetables)

Milling, Cotton



Trees Planting, Cutting

Greenhouse, Nursery, Sod

Please list all children less than 22 years of age

First	Last	Sex	School	Grade	Date of Birth

Please send completed form to:

SEK Education Service Center – Greenbush • 947 W. 47 Highway • Girard, KS 66743
greenbush.migrant@greenbush.org • (866) 806-9026 or (620) 724-6821 • FAX: (620) 724-6284

Kansas Migrant Education Program

Programa de Educación para Migrantes de Kansas

Encuesta para los padres

Nombre de los padres_____ Fecha_____

Domicilio _____

Número de teléfono_____

¿Se ha mudado en los últimos 3 años? ☐Si ☐No

¿Cuánto tiempo tienen viviendo en su domicilio actual? ____años ____meses

Domicilio anterior _____

¿Alguien de su familia ha trabajado en algo relacionado con los siguientes empleos? ☐Si ☐No

Ganado, Procesamiento, Empaque

Lechería

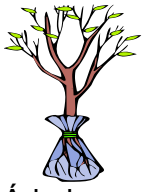
Huevo

Cultivando, Preparación de Tierra

Pescado

Cosechando (frutas y verduras)

Molinos Algodón



Árboles Podar, Plantar, Derribar o Cortar

Invernadero Vivero, Cultivar Pasto

Favor de escribir todos los nombres de los niños que viven en la casa (menores de 22 años)

Nombre	Apellido	Sexo	Escuela	Grado	Fecha de Nacimiento

Por favor envíe este formulario lleno a:

SEK Education Service Center – Greenbush • 947 W. 47 Highway • Girard, KS 66743
greenbush.migrant@greenbush.org • (866) 806-9026 or (620) 724-6821 • FAX: (620) 724-6284

GREENBUSH HOME LANGUAGE SURVEY

Upon enrollment, every student or parent/guardian must be given a Home Language Survey. This survey will be used to determine which students should be assessed for English proficiency. Knowledge of, or exposure to another language does not, in and of itself, qualify a student for ESOL services. If a language other than English is indicated in any of questions 1-4, the student will be assessed to determine eligibility for English for Speakers of Other Languages (ESOL) services. The assessments approved by Kansas State Department of Education include: The Language Assessment Scales (LAS)/LAS LINKS/Pre-LAS, the IDEA Proficiency Test (IPT)/Pre-IPT, the Language Proficiency Test Series (LPTS), and the Kansas English Language Proficiency Assessment (KELPA)/KELPA-P. If a student scores below proficient/fluent in any of the language domains: listening, speaking, reading, or writing, s/he is eligible for ESOL services. Please complete one form for each child.

Student Information:

Name	Grade
Address	Date of Birth
Date first enrolled in a school in the U.S.	Phone Number

Student Language Information:

1. What language did your child first learn to speak/use?
   English _____ Spanish _____ Other (please specify) _____
2. What language does your child speak/use at home? Do not include language learned in a class or through television or other such programming.
   English _____ Spanish _____ Other (please specify) _____
3. What language do you speak/use with your child?
   English _____ Spanish _____ Other (please specify) _____
4. What language do the adults regularly present or living in the home speak/use while in presence of the child?
   English _____ Spanish _____ Other (please specify) _____

Parent/Guardian Information:

Which language do you prefer? English ___Spanish ___ Other (specify)_____
(Please specify "written" or "spoken". To the extent practicable, communication from the school will be provided in this language.)

Migrant Education Program Information:

The Migrant Education Program (MEP) is authorized by Title I Part C of the Elementary and Secondary Education Act of 1965 (ESEA). The MEP provides formula grants to local education agencies to establish or improve education programs for children who may qualify for the Migrant Program. Please help us determine your child's eligibility for the Migrant Program by responding to the following questions.

Have you or a member of your family moved in the last 36 months to do, or apply for, agriculture or fishing related work, including dairies, nurseries, meat or vegetable processing, feed yards, or field work?
Yes _____No _____

Have your children moved with or to join the worker above in the past 36 months?
Yes _____ No _____

For the School: If the answer to either of the previous two questions is Yes, please contact the Greenbush Migrant office at Jennifer.delee@greenbush.org, toll free 866-806-9026, or fax 620-724-6284 and provide him a copy of this survey.

Signature of Parent or Guardian Date

Updated May 2017

ENCUESTA DE IDIOMA EN EL HOGAR

Al momento de inscripción, todo estudiante o padre/tutor debe tomar una Encuesta de Idioma en el Hogar. Esta encuesta será utilizada para determinar cuales estudiantes deben ser evaluados para aptitud de Idioma Inglés. Si en alguna de las preguntas de 1 a 4, se indica un idioma que no sea inglés el alumno será evaluado para determinar la elegibilidad de los Servicios de Idioma para Personas que Hablan Otros Idiomas (ESOL por sus siglas en inglés). Las evaluaciones aprobadas por el Departamento de Educación del Estado de Kansas incluyen: Las Escalas de Evaluación de Idioma (LAS, por sus siglas en inglés)/LAS LINKS/Pre-LAS, Examen de Aptitud IDEA (IPT, por sus siglas en inglés)/Pre-IPT, Serie de Exámenes de Aptitud de Inglés (LPTS, por sus siglas en inglés), y la Evaluación de Aptitud de Idioma Inglés de Kansas (KELPA)/KELPA-P. Si un estudiante obtiene un puntaje por debajo del nivel de aptitud/fluidez en cualquiera de las áreas del idioma: comprensión auditiva y expresión oral, lectura o escritura, él/ella puede ser elegible para los servicios ESOL. Por favor complete un formulario para cada niño.

Información del Estudiante

Nombre		Grado
Domicilio		Fecha de Nacimiento
Fecha de primera inscripción en una escuela en los Estados Unidos	Número de Teléfono	

Información del Idioma del Estudiante:

1. ¿Qué idioma aprendió primero hablar/utilizar su niño?
Inglés _____ Español _____ Otro (por favor especifique) _____

2. ¿Qué idioma habla/utiliza su niño más frecuentemente en el hogar?
Inglés _____ Español _____ Otro (por favor especifique) _____

3. ¿Qué idioma habla/utiliza usted más frecuentemente con su niño?
Inglés _____ Español _____ Otro (por favor especifique) _____

4. ¿Qué idioma hablan/utilizan más frecuentemente los adultos en el hogar?
Inglés _____ Español _____ Otro (por favor especifique) _____

Información del Padre/Tutor:

¿Qué idioma lee/escribe usted? Inglés ____ Español ___ Otros (especifique) _____

Información del Programa de Educación para Migrantes

El Programa de Educación para Migrantes (MEP por sus siglas en inglés) está autorizado por el Título I Parte C de la Ley de Educación Elemental y Secundaria de 1965 (ESEA por sus siglas en inglés). El MEP proporciona subsidios por fórmula a las agencias locales de educación para establecer o mejorar los programas de educación para los niños que pudieran calificar para el Programa de Migrantes. Por favor ayúdenos a determinar la elegibilidad de su niño para el Programa de Migrantes respondiendo las siguientes preguntas.

¿Se ha mudado usted o un miembro de su familia en los últimos 36 meses para hacer, o aplicar para, trabajo en algo relacionado con agricultura o pescadería, incluyendo lecherías, invernaderos, engordas, plantas procesadoras de carne, legumbres o frutas, o trabajo en el campo? Sí ___ No_____

¿Se han mudado sus niños con, o para reunirse con el trabajador mencionado en la primera pregunta, dentro de los últimos 36 meses? Sí ___ No_____

Si usted contestó si a cualquiera de las dos preguntas anteriores, por favor comuníquese con la oficina del Programa de Educación para Migrantes en Greenbush en jennifer.delee@greenbush.org o llame al 866-806-9026 o fax 620-724-6284

Firma del Padre o Tutor Fecha

Updated May 2017

USD 508 Baxter Springs Schools

Consent for Disclosure

Sharing Information with Other Programs

Dear Parent/Guardian:

You do not have to sign or send in this form to get reduced price or free Child Nutrition Program benefits for your children. If you do not sign the Consent for Disclosure, it will not affect eligibility for or participation in the Child Nutrition Programs.

To save you time and effort, information about your children's eligibility for reduced price or free Child Nutrition Program benefits may be shared with other programs for which your children may qualify. For the programs listed below, we must have your permission to share your information.

☒ **Yes**, I DO want school officials to share information about my children's eligibility for Child Nutrition Program benefits only with the programs I have checked below.

- ☒ Book Fee
- ☒ Technology Fee
- ☐ _____
- ☐ _____

If you checked yes to any or all of the boxes above, fill out the form below. Your information will be shared only with the programs you checked.

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Child's Name: _____ School: _____

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____

Address: _____

For more information, you may call or e-mail:

School Official's Name: Misha Himes Phone: 620-856-2375 E-Mail: himesm@usd508.org

Return this form to the address below by _____.

Address: 1108 Military Ave. Baxter Springs, KS 66713

This institution is an equal opportunity provider.