

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: \_\_\_\_\_

## Male Legal Guardian Information

**Name** (Last-First): \_\_\_\_\_

**Physical Address** (If different from student): \_\_\_\_\_

\_\_\_\_\_

**Day Phone:** \_\_\_\_\_

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

**Home Phone:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

## 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:**

\_\_\_\_\_

\_\_\_\_\_

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



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  
himesm@usd508.org

Phone: 620-856-2375

E-Mail:

Return this form to the address below by \_\_\_\_\_.

Address: 1108 Military Ave. Baxter Springs, KS 66713

This institution is an equal opportunity provider.





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**

Form Updated: 03/2022

## **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**

Insurance Plan \_\_\_\_\_

Member ID Number \_\_\_\_\_

Group Number \_\_\_\_\_

#### **Policy Holder Information:**

Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

#### **Secondary Insurance**

Insurance Plan \_\_\_\_\_

Member ID Number \_\_\_\_\_

Group Number \_\_\_\_\_

#### **Policy Holder Information:**

Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_





# Health Services

2024-2025 School Year

Baxter Springs USD #508

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

**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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> White                     | <input type="checkbox"/> Pacific Islander   |
| <input type="checkbox"/> Asian                          | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Decline to Specify |
|   | <input type="checkbox"/> Native Hawaiian           |   |

### 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 \_\_\_\_\_



**\*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                                      ☐ Pain                                      ☐ Other  
☐ Cleaning                                      ☐ Filling  
☐ Tooth pulled

**Medical History: Please check all that apply**

- |   |                                     |   |
|---|-------------------------------------|---|
| <input type="radio"/> Heart Murmur                      | <input type="radio"/> Diabetes      | <input type="radio"/> Congenital Heart Disorder |
| <input type="radio"/> Artificial Joints/<br>Pins/Screws | <input type="radio"/> Hepatitis     | <input type="radio"/> Artificial Heart Valve    |
| <input type="radio"/> Seizure Disorder                  | <input type="radio"/> Heart Disease | <input type="radio"/> Other                     |
| <input type="radio"/> Asthma                            |                                     |   |

**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

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## 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: \_\_\_\_\_

**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
<p><input type="checkbox"/> In a shelter _____ Shelter Name</p> <p><input type="checkbox"/> <i>Temporarily</i> with more than one family (due to loss of job, loss of housing, etc.)</p> <p><input type="checkbox"/> In a motel, car, or campsite</p> <p><input type="checkbox"/> In a temporary foster care awaiting permanent placement</p> <p><input type="checkbox"/> Alone without parental support (independent living Student)</p> <p><b>CONTINUE:</b> If you checked a box in this section, please <i>complete the rest of this form.</i></p>	<p><input type="checkbox"/> Choices in Section A do NOT apply.</p>  <p style="text-align: center;"><b>STOP:</b> If you checked this section, you do <i>not</i> need to complete the remainder of this form.</p>

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Male ☐ Female ☐

Parent/Guardian(s) \_\_\_\_\_

Present Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Last School Attended \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_

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**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



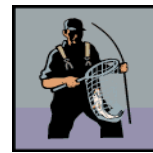
Dairy



Eggs



Cultivation,  
Preparation of  
soil



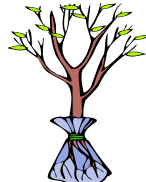
Fishing



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](mailto: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



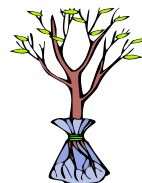
Pescado



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](mailto: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](mailto:Jennifer.delee@greenbush.org), toll free 866-806-9026, or fax 620-724-6284 and provide him a copy of this survey.

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Signature of Parent or Guardian

Date

## 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:

- ¿Qué idioma aprendió primero hablar/utilizar su niño?  
Inglés \_\_\_\_\_ Español \_\_\_\_\_ Otro (por favor especifique) \_\_\_\_\_
- ¿Qué idioma habla/utiliza su niño más frecuentemente en el hogar?  
Inglés \_\_\_\_\_ Español \_\_\_\_\_ Otro (por favor especifique) \_\_\_\_\_
- ¿Qué idioma habla/utiliza usted más frecuentemente con su niño?  
Inglés \_\_\_\_\_ Español \_\_\_\_\_ Otro (por favor especifique) \_\_\_\_\_
- ¿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](mailto:jennifer.delee@greenbush.org) o llame al 866-806-9026 o fax 620-724-6284**

Firma del Padre o Tutor

Fecha



# Lincoln School

801 Lincoln Ave.

Baxter Springs, KS 66713

620-856-3322 Fax: 620-856-4173

*Kenny Boeckman, Principal*

***"Where the Love of Learning Begins"***

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## Therapy Dog Consent Form

At Lincoln School we have the use of a Therapy Dog. The Therapy Dog's name is Luna. Luna is a hypoallergenic Golden-doodle that has completed board certified training and classes to be certified as a Therapy Dog. Luna has been individually trained and registered to work with her owner or handler to provide emotional support, well-being, comfort, or companionship to students. Therapy dogs are the personal property of the owner or handler and are not owned by the School Board.

By signing this form, you consent that your child may be working with a Therapy Dog at school. This animal has completed behavioral and health testing requirements allowing it to be in the school and is currently registered as a Therapy Dog by the Alliance of Therapy Dogs. The Therapy Dog also carries an insurance policy paid for by the owner of the animal.

I give permission for my child, \_\_\_\_\_,

to participate in therapy dog visits at Lincoln School in Baxter Springs.

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Signature of Parent or Guardian

Date