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: _____

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.)

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.