

BC _____
SS _____
IM _____

Student Information Sheet

2025-2026

(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:** _____

2025-2026 APPLICATION PACKET FOR FREE AND REDUCED PRICE SCHOOL MEALS

How to Apply for Free and Reduced Price School Meals.

Please use these instructions to help you fill out the application for free or reduced price school meals. You only need to submit one application per household, even if your children attend more than one school in USD 508/Baxter Springs Schools. The application must be filled out completely to certify your children for free or reduced price school meals. Please follow these instructions in order! Each step of the instructions is the same as the steps on your application. If at any time you are not sure what to do next, please contact 620-856-2375 himesm@usd508.org.

PLEASE USE A PEN (NOT A PENCIL) WHEN FILLING OUT THE APPLICATION AND DO YOUR BEST TO PRINT CLEARLY.

STEP 1: LIST ALL HOUSEHOLD MEMBERS WHO ARE INFANTS, CHILDREN, AND STUDENTS UP TO AND INCLUDING GRADE 12

Tell us how many infants, children, and school students live in your household. They do NOT have to be related to you to be a part of your household.

Who should I list here? When filling out this section, please include ALL members in your household who are:

- Children age 18 or under AND are supported with the household's income;
- In your care under a foster arrangement, or qualify as homeless, migrant, or runaway youth;
- Students attending USD 508, regardless of age.

A) List each child's name. Print each child's name. Use one line of the application for each child. If there are more children present than lines on the application, attach a second piece of paper with all required information for the additional children.	B) Is the child a student at USD 508? Mark 'Yes' or 'No' under the column titled "Student" to tell us which children attend USD 508. If you marked 'Yes,' write the name of the school and the grade level of the student in the 'School' and 'Grade' columns to the right.	C) Do you have any foster children? If any children listed are foster children, mark the "Foster Child" box next to the child's name. If you are ONLY applying for foster children, after finishing STEP 1 , go to STEP 4 . <u>Foster children who live with you may count as members of your household and should be listed on your application.</u> If you are applying for both foster and non-foster children, go to step 3.	D) Are any children homeless, migrant, or runaway? If you believe any child listed in this section meets this description, mark the "Homeless, Migrant, Runaway" box next to the child's name and <u>complete all steps of the application.</u>
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STEP 2: DO ANY HOUSEHOLD MEMBERS CURRENTLY PARTICIPATE IN FOOD ASSISTANCE, TAF, OR FDPIR?

If anyone in your household (including you) currently participates in one or more of the assistance programs listed below, your children are eligible for free school meals:

- Food Assistance (FA).
- Temporary Assistance for Families (TAF).
- The Food Distribution Program on Indian Reservations (FDPIR).

A) If no one in your household participates in any of the above listed programs: <ul style="list-style-type: none"> • Leave STEP 2 blank and go to STEP 3. 	B) If anyone in your household participates in any of the above listed programs: <ul style="list-style-type: none"> • Write a case number for FA, TAF, or FDPIR. You only need to provide one case number. If you participate in one of these programs and do not know your case number, contact Kansas Department for Children and Families. • Go to STEP 4.
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STEP 3: REPORT INCOME FOR ALL HOUSEHOLD MEMBERS

How do I report my income?

- Use the charts titled **"Sources of Income for Adults"** and **"Sources of Income for Children"**, printed on the back side of the application form to determine if your household has income to report.
- Report all amounts in GROSS INCOME ONLY. Report all income in whole dollars. Do not include cents.
 - Gross income is the total income received before taxes.
 - Many people think of income as the amount they "take home" and not the total, "gross" amount. Make sure that the income you report on this application has NOT been reduced to pay for taxes, insurance premiums, or any other amounts taken from your pay.
- Write a "0" in any fields where there is no income to report. Any income fields left empty or blank will also be counted as a zero. If you write '0' or leave any fields blank, you are certifying (promising) that there is no income to report. If local officials suspect that your household income was reported incorrectly, your application will be investigated.
- Mark how often each type of income is received using the check boxes to the right of each field.

3.A. REPORT INCOME EARNED BY CHILDREN			
<p>A) Report all income earned or received by children. Report the combined gross income for ALL children listed in STEP 1 in your household in the box marked "Child Income." Only count foster children's income if you are applying for them together with the rest of your household.</p> <p><i>What is Child Income?</i> Child income is money received from outside your household that is paid DIRECTLY to your children. Many households do not have any child income.</p>			
3.B REPORT INCOME EARNED BY ADULTS			
<p>Who should I list here?</p> <ul style="list-style-type: none"> When filling out this section, please include ALL adult members in your household who are living with you and share income and expenses, <u>even if they are not related and even if they do not receive income of their own.</u> Do NOT include: <ul style="list-style-type: none"> People who live with you but are not supported by your household's income AND do not contribute income to your household. Infants, Children and students already listed in STEP 1. 			
<p>B) List adult household members' names. Print the name of each household member in the boxes marked "Names of Adult Household Members (First and Last)." <u>Do not list any household members you listed in STEP 1.</u> If a child listed in STEP 1 has income, follow the instructions in STEP 3, part A.</p>	<p>C) Report earnings from work. Report all income from work in the "Earnings from Work" field on the application. This is usually the money received from working at jobs. If you are a self-employed business or farm owner, you will report your net income. See detailed instructions on the back of the application.</p> <p><i>What if I am self-employed?</i> Report income from that work as a net amount. This is calculated by subtracting the total operating expenses of your business from its gross receipts or revenue.</p>	<p>D) Report income from public assistance/child support/alimony. Report all income that applies in the "Public Assistance/Child Support/Alimony" field on the application. <u>Do not report the cash value of any public assistance benefits NOT listed on the chart.</u> If income is received from child support or alimony, only report court-ordered payments. Informal but regular payments should be reported as "other" income in the next part.</p>	
<p>E) Report income from pensions/retirement/all other income. Report all income that applies in the "Pensions/Retirement/ All Other Income" field on the application.</p>	<p>F) Report total household size. Enter the total number of household members in the field "Total Household Members (Children and Adults)." This number MUST be equal to the number of household members listed in STEP 1 and STEP 3. If there are any members of your household that you have not listed on the application, go back and add them. It is very important to list all household members, as the size of your household affects your eligibility for free and reduced price meals.</p>	<p>G) Provide the last four digits of your Social Security Number. An adult household member must enter the last four digits of their Social Security Number in the space provided. You are eligible to apply for benefits even if you do not have a Social Security Number. If no adult household members have a Social Security Number, leave this space blank and mark the box to the right labeled "Check if no SSN."</p>	
STEP 4: CONTACT INFORMATION AND ADULT SIGNATURE			
<p><i>All applications must be signed by an adult member of the household. By signing the application, that household member is promising that all information has been truthfully and completely reported. Before completing this section, please also make sure you have read the privacy and civil rights statements on the back of the application.</i></p>			
<p>A) Provide your contact information. Write your current address in the fields provided if this information is available. If you have no permanent address, this does not make your children ineligible for free or reduced price school meals. Sharing a phone number, email address, or both is optional, but helps us reach you quickly if we need to contact you.</p>	<p>B) Print and sign your name and write today's date. Print the name of the adult signing the application and that person signs in the box "Signature of adult."</p>	<p>C) Mail Completed Form to: 1108 Military Ave, Baxter Springs, KS 66713</p>	<p>D) Share children's racial and ethnic identities (optional). On the back of the application, we ask you to share information about your children's race and ethnicity. This field is optional and does not affect your children's eligibility for free or reduced price school meals.</p>

2025-2026 Household Application for Free and Reduced Price School Meals
Complete one application per household (use a pen not a pencil). https://schoolmealsapp.ksde.org/Home/welcome/D0508

STEP 1 List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related."
Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Read How to Apply for Free and Reduced Price School Meals for more information.

Child's First Name	MI	Child's Last Name	School	Grade	Student? Yes No	Foster Child	Homeless, Migrant, Runaway

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: Food Assistance, TAF, or FDIPIR?

If NO > Go to STEP 3. If YES > Write a case number here then go to STEP 4 (Do not complete STEP 3)
Case Number (Not EBT or Medicaid Number):
Write only one case number in this space.

STEP 3 List ALL Household Members and income for each member (before taxes and deductions) (Skip this step if you answered 'Yes' to STEP 2)

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income (before taxes and deductions) received by all children listed in STEP 1 here.

B. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often?					Public Assistance/ Child Support/Alimony	How often?				Pensions/Retirement/ All Other Income	How often?				
		Weekly	Every 2 Weeks	2x Month	Monthly	Annual		Weekly	Every 2 Weeks	2x Month	Monthly		Weekly	Every 2 Weeks	2x Month	Monthly	

Total Household Members (Children and Adults)
Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member
Check if no SSN

STEP 4 Contact information and adult signature. Return completed form to: 1108 Military Ave Baxter Springs, KS 66713

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Printed name of adult signing the form
Signature of adult
Today's date
Street Address (if available) Apt # City State Zip Daytime Phone and Email (optional)

Return completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistance Secretary for Civil Rights.

INSTRUCTIONS

Sources of Income

Sources of Income for Children	
Sources of Child Income	Example(s)
• Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
• Social Security - Disability Payments - Survivor's Benefits	• A child is blind or disabled and receives Social Security benefits • A Parent is disabled, retired, or deceased, and their child receives Social Security benefits
• Income from person outside the household	• A friend or extended family member regularly gives a child spending money
• Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Income from Self Employment: Self-employed persons may use income tax records for the preceding calendar year as a base to project the current year's net income, unless the current monthly income provides a more accurate measure. Report income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as interest on home payments, medical expenses, and other similar non-business deductions are not allowed in reducing gross business income. Additional income from other kinds of employment must be treated as separate and apart from the income generated or lost from your business venture. For example, if you operated a business at a net loss, but held additional employment for which a salary was received, the income for purposes of applying for reduced price or free meals would be the income from the salary only. The loss from the business cannot be deducted from a positive income earned in other employment.

Sources of Income for Adults		
<ul style="list-style-type: none"> • Salary, wages, cash bonuses • Net income from self-employment (farm or business) <p>If you are in the U.S. Military:</p> <ul style="list-style-type: none"> • Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) • Allowances for off-base housing, food, and clothing 	<ul style="list-style-type: none"> • Unemployment benefits • Worker's compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veteran's benefits • Strike benefits 	<ul style="list-style-type: none"> • Social Security (including railroad retirement and black lung benefits) • Private pensions or disability benefits • Regular income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

For purposes of this application, it is not possible to report a negative income from any business venture. The least income possible is zero (no income). The necessary information for arriving at allowable income from private business operation may be taken from your most recent U.S. Individual Income Tax Return - Form 1040, Schedule 1. Add together the amounts reported on the following lines:

Schedule 1, Line 3	\$ _____	Business Income or (Loss)
1040, Line 7	\$ _____	Capital Gain or (Loss)
Schedule 1, Line 4	\$ _____	Other Gains or (Losses)
Schedule 1, Line 5	\$ _____	Rental real estate, royalties, partnerships, S corporations, trusts, etc.
Schedule 1, Line 6	\$ _____	Farm Income or (Loss)
TOTAL	\$ _____	Gross Annual Income Before Any Deductions.

Computed Monthly Income \$ _____ Gross Annual Income ÷ 12 = Computed Monthly Income. Report in Step 3.

OPTIONAL

Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ☐ Not Hispanic or Latino
 Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Assistance (FA) Temporary Assistance for Families (TAF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign

Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

- (1) **mail**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
- (2) **fax:**
(833) 256-1665 or (202) 690-7442; or
- (3) **email:**
program.intake@usda.gov

This institution is an equal opportunity provider.

Do not fill out

For School Use Only – Annual Income Conversion: Weekly x 52, Bi-Weekly x 26, Twice a Month x 24, Monthly x 12

<input type="checkbox"/> Total Income: \$ _____ How Often (Circle One): W E2W 2M A M Multiple=Yearly <input type="checkbox"/> Categorical Eligibility (FA, TAF, FDPIR, Foster)	Household Size: _____	Eligibility: <input type="checkbox"/> Free OR <input type="checkbox"/> Reduced Price OR <input type="checkbox"/> Denied Notes: _____
Determining Official's Signature: _____		Approval/Denial Date: _____
Processor's Initials: _____		Review Date: _____

Return completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistance Secretary for Civil Rights.

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.



Office Use
USD: _____
Grade: _____

PATIENT REGISTRATION FORM				
LEGAL FULL NAME	LAST NAME	FIRST NAME	MIDDLE NAME	PREFERRED NAME
ADDITIONAL/FORMER NAMES (EX. MAIDEN NAME)		DATE OF BIRTH (MM/DD/YY)		SSN#
ADDRESS		CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ADDRESS)		MAILING CITY	MAILING STATE	MAILING ZIP CODE
HOME PHONE		CELL PHONE	WORK PHONE	
EMAIL ADDRESS (REQUIRED FOR PATIENT PORTAL ACCESS)			SEX ASSIGNED AT BIRTH	
PRIMARY CARE PROVIDER NAME CITY & STATE			<input type="checkbox"/> Male <input type="checkbox"/> Female	
RACE <i>(Check all that apply)</i>		ETHNICITY		EMERGENCY CONTACT
<input type="checkbox"/> White		<input type="checkbox"/> Not Hispanic/Latino		Emergency Contact Name:
<input type="checkbox"/> Black/African American		<input type="checkbox"/> Mexican, Mexican American, Chicano		Phone:
<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Puerto Rican		Relationship to Patient:
Asian		<input type="checkbox"/> Cuban		
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese		<input type="checkbox"/> Other Hispanic Latino		<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other
<input type="checkbox"/> Chinese <input type="checkbox"/> Korean		PREFERRED LANGUAGE		Emergency Contact Name:
<input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese		<input type="checkbox"/> English		Phone:
<input type="checkbox"/> Other Asian		<input type="checkbox"/> Spanish		Relationship to Patient:
Native Hawaiian/Pacific Islander		<input type="checkbox"/> Other:		
<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Marshallese		<input type="checkbox"/> Interpreter Needed:		<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other
<input type="checkbox"/> Guamanian or Charmorro		PHARMACY		
<input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander		<input type="checkbox"/> Apothecare Pharmacy <i>(CHC in-house pharmacy)</i> Location:		<input type="checkbox"/> Other Pharmacy
<input type="checkbox"/> Decline to Specify				
INSURANCE – CHECK ALL THAT APPLY <i>(PLEASE PROVIDE COPY OF CARD)</i>				
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Medicare Advantage Plan <input type="checkbox"/> Commercial Insurance <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Dental Insurance <input type="checkbox"/> State Medicaid <small>Kan Care, SoonerCare, MO HealthNet</small> <input type="checkbox"/> CHIP <input type="checkbox"/> Other Medicaid				
PRIMARY INSURANCE POLICY HOLDER			SECONDARY INSURANCE POLICY HOLDER	
FULL NAME	DATE OF BIRTH (MM/DD/YY)		FULL NAME	DATE OF BIRTH (MM/DD/YY)
INSURANCE PLAN	SSN#		DATE OF BIRTH	SSN#
INSURANCE ID NUMBER	INSURANCE GROUP NUMBER		INSURANCE ID NUMBER	INSURANCE GROUP NUMBER
POLICY HOLDER'S RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other			POLICY HOLDER'S RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
RESPONSIBLE PARTY <i>(PERSON RESPONSIBLE FOR PAYING PATIENT ACCOUNT)</i>				
FULL NAME	DATE OF BIRTH (MM/DD/YY)		SSN#	PRIMARY PHONE
EMAIL	ADDRESS		CITY	STATE ZIP CODE



Office Use	
USD:	_____
Grade:	_____

PATIENT LAST NAME:

FIRST NAME:

DATE OF BIRTH:

CONSENT TO TREAT

I give consent for treatment by Community Health Center of Southeast Kansas, Inc. (CHC/SEK) for medical, dental and/or mental health services. 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 (example: vision and hearing screenings).

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.

With my signature, I certify that I understand the above and that I am authorized to sign for the patient listed above on this Patient Registration/Consent for Treatment Form

_____	_____	____/____/____
Signature of Patient, Agent, Representative, Parent, Legal Guardian or Responsible Party	Relationship to Patient	Month/Date/Year



DENTAL OUTREACH FORM

Community Health Center of Southeast Kansas, Inc. (CHC/SEK) provides dental services at your student's school. Students are invited to participate in dental outreach services. No student will be denied services based on insurance status or ability to pay. If available, insurance will be billed.

STUDENT NAME					
LEGAL FULL NAME	LAST NAME	FIRST NAME	MIDDLE NAME	PREFERRED NAME	
ADDITIONAL/FORMER NAMES (EX. MAIDEN NAME)		DATE OF BIRTH (MM/DD/YY)	SSN#	SCHOOL LOCATION	GRADE
INSURANCE – CHECK ALL THAT APPLY					
<input type="checkbox"/> Commercial Dental Insurance <input type="checkbox"/> Children's Health Insurance Program (CHIP) <input type="checkbox"/> State Medicaid <input type="checkbox"/> No Dental Insurance					
PRIMARY INSURANCE POLICY HOLDER			SECONDARY INSURANCE POLICY HOLDER <input type="checkbox"/> N/A		
FULL NAME		DATE OF BIRTH (MM/DD/YY)	FULL NAME		DATE OF BIRTH (MM/DD/YY)
INSURANCE PLAN		SSN#	INSURANCE PLAN		SSN#
INSURANCE ID NUMBER		INSURANCE GROUP NUMBER	INSURANCE ID NUMBER		INSURANCE GROUP NUMBER
POLICY HOLDER'S RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____			POLICY HOLDER'S RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____		
STUDENT'S HEALTH HISTORY (PLEASE MARK ALL THAT APPLY)					
<input type="checkbox"/> Hepatitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Artificial Joint/Valve <input type="checkbox"/> Asthma <input type="checkbox"/> Alpha Gal <input type="checkbox"/> Heart Disorder <input type="checkbox"/> Other: _____					
Food, Drug, and/or Other Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No			Please List Allergies: _____ _____		
Required by a Provider to take pre-medications (antibiotics) prior to dental treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No			Please State Condition: _____ _____		
Surgeries, Hospitalizations, or Other Health Conditions CHC/SEK should know: <input type="checkbox"/> Yes <input type="checkbox"/> No			Please Explain: _____ _____		
Any Current Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No			Please List: _____ _____		

CONSENT TO TREAT

As parent or legal guardian of the student named above, I give CHC/SEK permission to provide dental services by CHC/SEK clinical professionals as 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 (1) 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).** *You will receive a phone call before performing any local anesthesia or removing any baby teeth.*

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

Parent/Guardian Signature _____ DATE (MM/DD/YEAR) ____/____/____

OFFICE USE ONLY					
SCRN #: _____	FR: _____	P/F/S #: _____	ITR: _____	EXT: _____	CARRIES RISK: <input type="checkbox"/> MOD <input type="checkbox"/> HIGH
EO: 3 _____ 14 _____ 19 _____ 30 _____			SDF: _____		
REFERRAL: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: _____		TEACHER: _____		HYG INITIALS: _____	

Health Services

2025-2026 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

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 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>CONTINUE: 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;">STOP: 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 ____

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.)



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"

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.

Signature of Parent or Guardian

Date