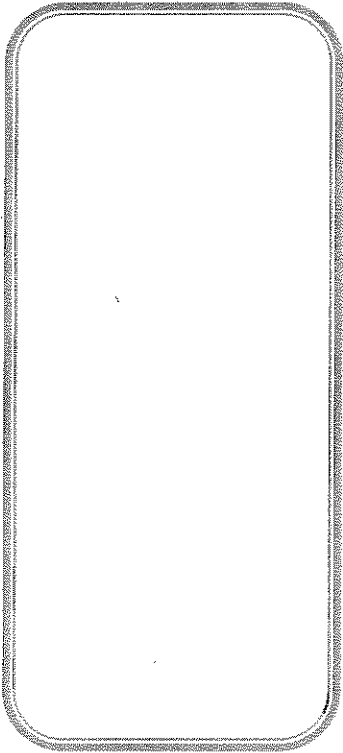


Educating with excellence, inspiring learners for life!



3-Year Old Preschool _____	6th Grade _____
4-Year Old Preschool _____	7th Grade _____
Kindergarten _____	8th Grade _____
1 st Grade _____	9th Grade _____
2 nd Grade _____	10th Grade _____
3 rd Grade _____	11th Grade _____
4 th Grade _____	12th Grade _____
5 th Grade _____	

Please review the following forms. If any corrections are made,
please initial and date the changed item.
When all the information is correct, please sign the line next to your child's grade.

GENERAL STUDENT INFORMATION

Please print clearly

STUDENT NAME: _____

BIRTH DATE: _____

GENDER: _____

SS#: _____

PARENT'S NAME(S): _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____

WORK/EMERGENCY PHONE(S): _____

CELL PHONE NUMBER(S): _____

EMAIL ADDRESS (OPTIONAL): _____

PASSWORD (TO VIEW STUDENT'S INFO ON THE WEB) _____

LANGUAGE SPOKEN IN HOME (IF NOT ENGLISH) _____

- ETHNICITY:
- | | |
|---|---|
| <input type="checkbox"/> HISPANIC/LATINO | <input type="checkbox"/> AMERICAN INDIAN/PACIFIC ISLANDER |
| <input type="checkbox"/> ASIAN | <input type="checkbox"/> BLACK/AFRICAN-AMERICAN |
| <input type="checkbox"/> WHITE | <input type="checkbox"/> HAWAIIAN/PACIFIC ISLANDER |
| <input type="checkbox"/> OTHER (PLEASE SPECIFY) | _____ |

TRANSFER STUDENTS: START DATE: _____

LAST SCHOOL ATTENDED: _____

- SERVICES NEEDED:
- | | |
|--|-------------------------------------|
| <input type="checkbox"/> SPECIAL ED. | <input type="checkbox"/> IEP |
| <input type="checkbox"/> TITLE READING | <input type="checkbox"/> TITLE MATH |
| <input type="checkbox"/> 504 | <input type="checkbox"/> ELL |

PICK-UP PERMISSION/PICTURE AND VIDEO RELEASE/ TRAVEL AND ACTIVITY AUTHORIZATION

CHILD'S FULL NAME: _____

I HEREBY GIVE PERMISSION FOR:

1. My child to leave the center with the following persons named below. It is the parent's responsibility to notify the school if any changes happen throughout the year.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

If there are separation or divorce issues we should know about, please explain.

Names of person(s) who may NOT pick up your child:

2. My child to be photographed or videotaped for use by the center for the purpose of publicity and progress monitoring. (Circle one) Yes / No
3. My child to leave the facility for trips in a car or on public transportation to special places, shopping trips, etc. I understand that I will be notified before such activities.

Restrictions on such trips include:

- 1) All work must be completed before leaving the facility
- 2)
- 3)

- 4) My child to use the internet. (Circle one) Yes / No

Annual Health Information

Student Name _____ Birth Date _____ Gender _____

Health Concerns

Please put an (X) if your child has any of these health concerns:

____ ADHD/ADD

____ Allergies (to what?) _____

If your child has food allergies do you give consent to post information about your child's allergies in food preparation areas? Yes No

____ Asthma or other breathing problems?

a. Has your child ever been diagnosed by a doctor with asthma? Yes No

b. Has your child had episode(s) of wheezing (whistling in the chest?)
in the last 12 months? Yes No

c. In the last 12 months, have you heard your child wheeze or cough after
playing? Yes No

d. Other breathing problems? (Please describe)

____ Bladder or bowel problems? (Please describe)

____ Chicken Pox (Please list month and year) _____

____ Diabetes: Type 1 Type 2

Managed By: Insulin Injections Insulin Pump Diet Only Oral Meds

____ Heart Problems? (Please describe): _____

____ Seizures? Type (Please describe): _____

____ Social/Emotional/behavioral/mental health concerns? (Please describe) _____

Is your child pregnant? Yes No If yes, when is the due date? _____
Does your child have children? Yes No If yes, what age(s)? _____

____ Other health concerns/significant history of problems. (Please describe) _____

____ Activity restrictions? (Please describe): _____

____ Skin conditions (please describe) _____

Any surgeries or hospitalizations within the past year? Yes No
If yes, please explain: _____

Do you give consent to school personnel to apply sunscreen to all exposed skin that is provided by parent?
 Yes No Parent Initial _____

Do you give consent to school personnel to apply insect repellent containing deet that is provided by parent?
 Yes No Parent Initial _____

MEDICATIONS:

Please list **ALL** medications that your child takes/uses everyday or when needed. A consent form is **required** for **ALL** medications taken at school.

Medication Name	Purpose	Dose	How often taken?
-----------------	---------	------	------------------

VISION

- Contacts/glasses prescribed
- Wears glasses/contacts all of the time
- Wears glasses in classroom only
- Other (please describe) _____

HEARING

- Frequent ear infections (3+ per year)
- Has ear tube(s) Date inserted _____
- Hearing loss right ear left ear
- Hearing aid(s) right ear left ear
- Other (please describe): _____

Comments:

Please use this space to describe problems listed.

Health Insurance:

- My child has health insurance. What kind? _____
- My child does not have health insurance.

HEALTH CARE PROVIDERS:

If there is no family physician, will the choice made by the school be satisfactory? Yes No

Hospital preference: _____

Name of Doctor or Clinic	Location and Phone	Approximate date of last exam
Primary Health Provider(regular doctor)		
Eye Specialist		
Ear Specialist		
Dentist		
Other Specialist (specify type)		

Consent for Medical Treatment

Iowa Law requires a parent(s) or guardian(s) written consent before their son/daughter can receive emergency treatment, unless in the opinion of a physician the treatment is necessary to prevent death or serious injury.

As the parent(s) or legal guardian(s) of the child named on this card I authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my child. I understand that this written consent is given in advance of any specific diagnosis or hospital care.

This written authorization is granted only after a reasonable effort has been made to contact me.

Student Name Parent/Guardian Signature Date

Can this health information be shared with North Kossuth school staff on a need-to-know basis?

- YES
- NO

Parent/Guardian Signature: _____ Daytime Phone: _____

Print Parent/Guardian Name: _____ Date: _____

Physical Examination

Completed by Physician

Student Name _____

Height: _____

Weight: _____

<i>Neuromuscular System</i>	
<i>Orthopedic</i>	
<i>Skin</i>	
<i>Nose</i>	
<i>Throat and Mouth</i>	
<i>Eyes</i>	
<i>Ears</i>	
<i>Glands</i>	
<i>Heart</i>	
<i>Lungs</i>	
<i>Abdomen</i>	
<i>Urinalysis</i>	
<i>Blood Count</i>	
<i>Blood Pressure</i>	
<i>Lead Screening – if previously screened, send a copy of the results.</i>	
<i>Vision and Hearing</i>	

Physician Comments: _____

Physician Signature: _____ Date: _____

Special request:

If you would like a copy of your student's report card, mid-term information, etc., sent to another parent not living at this address, please fill out the information below:

Parent Name _____

Relation to Student _____

Address _____

City, State, ZIP _____