



Other ID # \_\_\_\_\_

\_\_\_\_\_  
(Name of school)

\_\_\_\_\_  
(Today's Date)

Attended Lawrence Public Schools Yes \_\_\_\_\_ No \_\_\_\_\_

Name of LPS school/Date attended \_\_\_\_\_

Name must be as it appears on birth certificate:

Student Legal Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Middle Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: Male / Female

Student's Email Address \_\_\_\_\_ Grade level: 9<sup>th</sup> 10<sup>th</sup> 11<sup>th</sup> 12<sup>th</sup>

Race/Ethnicity: a) Is the student Hispanic/Latino or of Spanish origin?  Yes  No

b) Select one or more races from the following racial groups: \_\_\_\_\_

- 1=American Indian or Alaska Native      2=Asian      3=Black or African American
- 4=Native Hawaiian or Other Pacific      5=White

Does this student receive special education services? Yes \_\_\_\_\_ No \_\_\_\_\_ Primary Exceptionality: \_\_\_\_\_

If yes, please provide Health Insurance information:  Medicaid  Healthwave  Other \_\_\_\_\_

Primary Guardian residing at the student's address:

Circle One: Father / Mother / Step / Other

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Residential Address (No PO Box) \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ Employer \_\_\_\_\_

Call Order \_\_\_\_\_ Unlisted \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

For online access to student records, please provide a current email address: \_\_\_\_\_

Secondary Guardian residing at the student's address:

Circle One: Father / Mother / Step / Other

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Residential Address (No PO Box) \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ Employer \_\_\_\_\_

Call Order \_\_\_\_\_ Unlisted \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

For online access to student records, please provide a current email address: \_\_\_\_\_

Parent **NOT residing** at the above address: Extra Mailings:  Yes  No E-mail address \_\_\_\_\_

Circle One: Father / Mother

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Residential Address (No PO Box) \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ Employer \_\_\_\_\_

Call Order \_\_\_\_\_ Unlisted \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

For online access to student records, please provide a current email address: \_\_\_\_\_

Student lives with:  Both parents  Mother  Father  Stepparent  Guardian  Other \_\_\_\_\_

List Phone number(s) for Automated Phone Messages: \_\_\_\_\_

**What school did student attend during the 2010-2011 school year?**

School Name \_\_\_\_\_ City/State \_\_\_\_\_

Kansas school entry date: \_\_\_\_\_ United States school entry date: \_\_\_\_\_

What language is usually spoken in the home? \_\_\_\_\_

What is the first language of the student? \_\_\_\_\_

Does either parent have a first language other than English? \_\_\_\_\_

Has your family moved in the last 36 months to seek or obtain agriculture or fishing-related work?  Yes  No

If yes, was the move from one school district to another?  Yes  No

**Person(s) other than physician to call in case of illness or emergency if unable to reach parent:**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

**Has the student ever been Expelled or Suspended \_\_\_\_\_ Yes \_\_\_\_\_ No**

When \_\_\_\_\_ Length of time \_\_\_\_\_ School \_\_\_\_\_

When \_\_\_\_\_ Length of time \_\_\_\_\_ School \_\_\_\_\_

I have read and agreed to the Acceptable Use Policy. I give permission for my student to use school computers, including Internet, under the supervision of school personnel. \_\_\_\_ initials

I have read and agree to the Blanket Authorization to participate in field trips within the Lawrence Area. I give permission for my student to attend trips within Lawrence planned by the school and under the supervision of school personnel. \_\_\_\_ initials

I have reviewed and understand the responsibilities of students riding Lawrence Public School buses and agree to assume full responsibility for my child's conduct on the bus. \_\_\_\_ initials

I give permission for my student's photographs, videotape coverage, voice and/or student work to be used in school-related publications, website, social media or promotional pieces. \_\_\_\_ initials

I agree to the above statements. \_\_\_\_\_  
Parent/Guardian signature

**If the parent or guardian requires special accommodations due to a disability, please inform the school office.**

Lawrence Public Schools  
**PLEASE RETURN TO THE SCHOOL NURSE**  
 HEALTH HISTORY FORM FOR \_\_\_\_\_ SCHOOL YEAR

**STUDENT INFORMATION**

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_  
 Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  F  M School last attended \_\_\_\_\_  
 Mother/Guardian's Name \_\_\_\_\_ Wk # \_\_\_\_\_  
 Father/Guardian's Name \_\_\_\_\_ Wk # \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Cell phone: Mother \_\_\_\_\_ Cell Phone: Father \_\_\_\_\_  
 Student lives with  Both Parents  Mother  Father  Guardian  
 Physician \_\_\_\_\_ Phone \_\_\_\_\_ Hospital \_\_\_\_\_  
 Dentist \_\_\_\_\_ Phone \_\_\_\_\_

**EMERGENCY CONTACTS (in cases when a Parent/Guardian cannot be reached)**

1. Name \_\_\_\_\_ Hm/Cell # \_\_\_\_\_  
 2. Name \_\_\_\_\_ Hm/Cell # \_\_\_\_\_

**HEALTH CONDITIONS (check those that apply)**

<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Allergies (Life Threatening)	<input type="checkbox"/> Endocrine Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> G.I. Disorder (Stomach / Intestinal)
<input type="checkbox"/> Arthritis / Connective Tissue	<input type="checkbox"/> Genetic Disorder
<input type="checkbox"/> Asthma / Reactive Airway	<input type="checkbox"/> Headaches Type:
<input type="checkbox"/> Behavioral / Emotional / Psychological	<input type="checkbox"/> Hearing Impaired Hearing Aid <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Brain / CNS Disorder	<input type="checkbox"/> Musculoskeletal Disorders
<input type="checkbox"/> Cancer	<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Cardiovascular (Heart / Blood Disease)	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Skin Disease
<input type="checkbox"/> Chicken Pox <b>Date:</b> _____	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Urinary / Kidney Disease
<input type="checkbox"/> Dental	<input type="checkbox"/> Visually Impaired Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Developmental Delay	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Other (Please List)	

**Please fully explain any answers checked above (include severity and symptoms of any allergies)**

\_\_\_\_\_

Please list any medication the student takes on a regular basis \_\_\_\_\_

\_\_\_\_\_

Please list any other factors that the school nurse, counselor or your child's teacher(s) should know of which might affect the student's school experience \_\_\_\_\_

\_\_\_\_\_ 504 Plan on file?  YES  NO

**Statement of Consent:** This information will be held in confidence and disclosed to school personnel to the extent necessary to protect the health of the student. In order to better serve the health needs of my child, I hereby give permission for the transfer of health information to school and other appropriate health professionals, including immunizations status to state and local authorities as requested. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. If transportation by ambulance is required, this may be obtained.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# REQUEST FOR SECONDARY STUDENT RECORDS

Date: \_\_\_\_\_

Name of Student: \_\_\_\_\_

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

State Student ID: \_\_\_\_\_

**Please FAX UNOFFICIAL school records as soon as possible.**  
**Please MAIL official records.**

RECORDS REQUESTED FROM PREVIOUS SCHOOL: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Years attended pervious school: \_\_\_\_\_ to \_\_\_\_\_

Current Grade Level: \_\_\_\_\_ Last grade level attended: \_\_\_\_\_

Please send the records which are checked below:

- Permanent Records
- Grades (Current Semester Grades required)
- Attendance Records
- Immunization Records
- Current Transcripts
- Discipline Records
- Special Education File
- Standardized Test Results
- Other Records: \_\_\_\_\_

I hereby authorize the disclosure of all educational, medical, and psychological information regarding the above student to go to or be received from the school indicated on this form. I understand that the information thus obtained will be treated in a confidential manner.

\_\_\_\_\_  
Parent/Legal Guardian's Signature (if required)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone