

# Elementary Student(s) Family Information Sheet



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

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

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

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

**Student(s) family name (legal last name)** \_\_\_\_\_

List each student(s) by grade level who will be enrolled in this school for current year.

**Race/Ethnicity: \*Select one or more races from the following racial groups and record in \*Race column below:**

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

Grade Level in School	Male/Female	Last Name <i>(name on birth certificate)</i>	First Name, Middle Initial <i>(name on birth certificate)</i>	Hispanic, Latino, or Spanish origin? <i>(yes or no)</i>	*Race <i>(see below)</i>	Birth City and Country	Date of Birth	Last School Enrolled City/State	I.D.# <i>(School Use)</i>
							/ /		
							/ /		
							/ /		
							/ /		

**Primary Guardian residing at the student's address:**

Circle One: Father / Mother / Step / Other    Permission to pick up child: \_\_\_\_ Yes \_\_\_\_ No

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    Permission to pick up child: \_\_\_\_ Yes \_\_\_\_ No

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    Permission to pick up child: \_\_\_\_ Yes \_\_\_\_ No

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(s) live(s) with:  Both parents  Mother  Father  Stepparent  Guardian  Other \_\_\_\_\_

**Emergency Contact Information:**

Please list the phone number (s) used for the Phone Automated Message System: \_\_\_\_\_

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Permission to pick up child: \_\_\_\_ Yes \_\_\_\_ No

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Permission to pick up child: \_\_\_\_ Yes \_\_\_\_ No

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

What language is usually spoken in the home? \_\_\_\_\_ Does either parent have a first language other than English? \_\_\_\_\_

Student Name	Kansas School Entry Date	United States Entry Date	First Language of the student	Name of Daycare /Preschool for before/after elementary school hours	Phone number for daycare/preschool

List all children (including preschool) in the family who are not listed in the previous table. Please begin with the eldest child.

Legal Name (Last, First, Middle names as listed on birth certificate)	M/F	Date of Birth

**Health Insurance information:**

Student(s) Legal Name (on birth certificate)

\_\_\_\_\_  Medicaid  Healthwave  Other \_\_\_\_\_  
 \_\_\_\_\_  Medicaid  Healthwave  Other \_\_\_\_\_  
 \_\_\_\_\_  Medicaid  Healthwave  Other \_\_\_\_\_

I have read and agreed to the Acceptable Use Policy. I give permission for my student(s) 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(s) 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(ren's) conduct on the bus. \_\_\_\_ initials

I give permission for my student's(s') photographs, videotape coverage, voice and/or student(s) work to be used in school-related publications/website 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    Yes    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    Yes    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

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

**Lawrence Public Schools  
Health Services**

**Health Requirements for New Students**

The principal of each Lawrence Public school is responsible for enforcing the Kansas School Immunization Law (K. S. A. 725209 amended 1981). State law requires that prior to admission each student must present certification by a licensed physician or local health department showing that the student has received at least one of each of the following immunizations or is in the process of receiving immunizations against diphtheria, pertussis (up to age 7), tetanus, polio, measles, rubella and mumps. In addition, as of the 2011 – 2012 school year children entering Kindergarten, first, second and seventh grades are required to have three immunizations for Hepatitis B and **TWO** Varicella (chickenpox) immunizations. Children entering third through sixth grades and eighth through eleventh grades are additionally required to have three immunizations for Hepatitis B and one Varicella (chickenpox) immunization. If your child has had the chickenpox disease we need documentation by a licensed physician. Additionally, a booster **Tdap** is required for all seventh through ninth graders if no previous history of Tdap vaccination. The two alternatives to immunizations that are recognized by the Kansas State Department of Health and Environment are a medical exemption endorsed in writing by a licensed physician, or a religious exemption sign by the parent or guardian.

**Medical examinations:** A school health assessment (“physical exam”) performed by a licensed health care provider is required for all students up to the age of 9 and under who are entering a Kansas school for the first time. This exam must have been completed by a private practitioner or at a county health department within 12 months prior to school entry. For more information or an appointment, contact the Lawrence-Douglas County Health Department at 843-0721.

If your child has not received complete immunization against the listed diseases and one of the legal alternatives is not applicable, progress toward completion must be demonstrated thirty (30) days after notification of needed immunizations. If your child has not presented a health assessment to the school upon admission, the examination must be completed within ninety (90) days after admission. Failure to present certification by a licensed physician or health department that your child has fulfilled these requirements shall be grounds for exclusion until such requirements have been satisfied.

All new students are required to submit a health history that has been completed by a parent or guardian as part of the enrollment process.

I hereby certify that I have read and understand the above school admission requirements for my child. **I also give permission for the school immunization record to be released to the Kansas Department of Health and Environment, the Lawrence Douglas County Health Department, and the Kansas Immunization Program including the immunization registry for the purpose of assessment, reporting, and prevention of disease.**

\_\_\_\_\_  
(Name of Child) (Date of Birth) (Grade)

\_\_\_\_\_  
(Parent/Guardian Signature) (Date)

Last school attended \_\_\_\_\_  
School City State

**Return form to School Nurse**



# REQUEST FOR STUDENT RECORDS

\_\_\_\_\_ School

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

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

Lawrence, KS 6604\_\_\_\_

Current Grade Level: \_\_\_\_\_

Office: (785) 832 – \_\_\_\_\_

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

Fax: (785) 832 – \_\_\_\_\_

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

\_\_\_\_\_  
Name of Person Taking Request for Student Records

RECORDS REQUESTED  
FROM PREVIOUS SCHOOL:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

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