EMERGENCY INFORMATION/PROCEDURE CARD

IMPORTANT: RETURN FIRST WEEK OF SCHOOL

(PLEASE PRINT)

Student Name _____
LAST FIRST MIDDLE

Date of Birth _____ Grade Level _____ Sex: M or F

Home Address _____ Home Phone _____

LOCATIONS PARENTS CAN BE REACHED IF NOT AT HOME:

Father _____
LOCATION/ADDRESS HOURS PHONE

Mother _____
LOCATION/ADDRESS HOURS PHONE

NAME OF LOCAL PERSON OR RELATIVE TO CONTACT IF PARENT(S) CAN NOT BE REACHED:

Name _____

Address _____ Phone _____

REVERSE SIDE MUST BE COMPLETED AND SIGNED.

BOSS Printing, Glendive, MT/M876-WibEmerg Crd **(6-09)**

RELEASE In case of emergency, accident, or serious illness to the student named on this card in which medical treatment is required, I (parent/guardian) request the school to contact me. If the school is unable to reach me, my signature below authorizes the school to exercise their own judgement in contacting the physician indicated below and to follow his/her instructions. If this physician is unavailable, the school may make whatever arrangements are necessary or transport the student to a hospital emergency room.

Parent/Guardian Signature _____ _____
DATE SIGNED

Remarks _____

Does this student have any major or unusual health conditions? Yes ☐ No ☐

If yes, please specify. _____

Allergies _____ Other Conditions _____

Local Physician's Name _____

Address _____

Office Phone _____ Other Phone _____

IMPORTANT NOTE: Please notify school officials immediately concerning changes to any information listed on this card.

STARS Preschool Enrollment Form

Dear Parents,

We are so excited that your child is participating in a STARS Preschool Classroom. Did you know that your classroom was funded by the State of Montana legislature, as part of Governor Bullock's emphasis on high quality preschool experiences for our youngest citizens? This funding was granted for two years as a pilot program.

As part of enrolling your child in a STARS Preschool classroom, we're requesting some information from you to help us with evaluating the success of the pilot project. Thank you in advance for your cooperation in completing the following enrollment form. Data will be anonymous as part of a larger evaluation plan.

Stars Preschool Program

Please select the program providing STARS Preschool for your child

- ☐ ABC Academy
- ☐ Alberton Public School
- ☐ Beartooth Children Center
- ☐ Cherry Valley STARS Preschool Program (CVSPP)
- ☐ Discovery Place Child Care
- ☐ Early Childhood Center at Flathead Valley Community College
- ☐ Eastgate Elementary, EHPS Dist. 9
- ☐ Explorers Academy, Billings Headstart
- ☐ Explorers Academy, Laurel Headstart
- ☐ Helena Public Schools Montessori Preschool at Hawthorne
- ☐ Lockwood STARS Preschool #1
- ☐ Lockwood STARS Preschool #2
- ☐ Lolo School District
- ☐ Kountry Kare
- ☐ Marion School District
- ☐ Ronan School District No. 30 KWN Ronan
- ☐ Ronan School District No. 30 Pablo
- ☐ Small Wonder Child Care Inc.
- ☐ Stepping Stones Preschool
- ☐ Troy School District #1
- ☐ Wibaux Public School

Child Information

Name of Child

First Name | Middle Initial | Last Name

Child's Social Security Number

Date of Birth

MM DD YYYY

Gender

- ☐ Male
- ☐ Female

What is your child's racial or ethnic identification?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ White

Please tell us more about your family or child

Please check all that apply

- ☐ Receiving early intervention services and support for my special needs child
- ☐ Currently participating or have participated in a home visiting program
- ☐ Currently working with or have worked with Child and Family Services
- ☐ My child has special health care needs (such as food allergies, asthma, diabetes, special dietary restrictions, on extended prescribed medication, etc.)
- ☐ My child is an enrolled Tribal member or lives on a reservation
- ☐ I am a teen parent or was a teen parent with my child
- ☐ I have received assistance through the Best Beginnings Child Care Scholarship Program *
- ☐ My family has been or is homeless or at risk of being homeless

* If your child receives the Best Beginnings Child Care Scholarship, please notify your local Child Care Resource and Referral Agency that your child is participating in a STARS Preschool classroom. The Best Beginnings Child Care Scholarship cannot be used for hours in which your child is participating in STARS Preschool; only hours before and after STARS Preschool will be covered.

Please list any supportive services or developmental screenings, in addition to doctor's visits, your child has received (Examples: Home visiting, Speech Therapy, Child Find)

Parent Information

How many individuals live in your home? ☐

Annual household income from all income sources

- ☐ Less than $10,000
- ☐ $11,000 - $30,000
- ☐ $31,000 - $50,000
- ☐ $51,000 - $70,000
- ☐ $71,000 - $90,000
- ☐ More than $90,000

Employment Parent #1

- ☐ Unemployed
- ☐ Employed – Part Time
- ☐ Employed – Full Time
- ☐ Self Employed
- ☐ Full-Time Student
- ☐ Retired
- ☐ Other (please Specify)

Education Parent #1

- ☐ High School
- ☐ Some College
- ☐ Associate's
- ☐ Bachelor's and above
- ☐ Other (please specify)

Employment Parent #2

- ☐ Unemployed
- ☐ Employed – Part Time
- ☐ Employed – Full Time
- ☐ Self Employed
- ☐ Full-Time Student
- ☐ Retired
- ☐ Other (please Specify)

Education Parent #2

- ☐ High School
- ☐ Some College
- ☐ Associate's
- ☐ Bachelor's and above
- ☐ Other (please specify)

Describe the care and education your child received prior to enrolling in a STARS Pre-school. Select any that apply

- ☐ My child has attended a child care program
- ☐ My Child has attended preschool
- ☐ My Child has been cared for at home with a parent, guardian or relative caretaker
- ☐ My child has been in early head start
- ☐ My Child has attended head start

Will your child require before or after school care aside from the services offered through STARS preschool?

- ☐ Yes
- ☐ No

If yes, please provide the type of program and average hours per week your child will attend

Program Type

Average Hours Per week

Do you anticipate, enrolling your child in STARS Preschool program will increase or decrease your child care expense?

- ☐ Childcare expense will decrease
- ☐ Childcare expense will increase
- ☐ Childcare expense will remain the same

Please explain the anticipated changes to your child care costs.

Wibaux Public Schools Admission Form

Date: _____

Grade Entering: _____

DO NOT FILL OUT
Office Use ONLY
Student ID# _____
Entry Date _____
Teacher _____
Student Records Date Requested _____

Student Information

Student Full Name:

_____, _____ _____

Last First Middle

Address: _____

_____

Name and address of school student most recently attended:

Name: _____

Address: _____

_____

Date of Birth:	Birthplace: City State	Male ☐ Female ☐
Immunization Records Present: ☐ Yes ☐ No Birth Certificate Present: ☐ Yes ☐ No	My child receives the following: Check all that apply ☐ Title ☐ EMH ☐ Speech ☐ TMH ☐ LD ☐ ED Is your child on an IEP? ☐ Yes ☐ No	Ethnicity:(Please check all that apply) ☐ Hispanic ☐ Native American ☐ Asian ☐ Black ☐ Pacific Islander ☐ White

Parent Information

Mother's Name: _____ _____ Last First	Check One: ☐ Legal Parent ☐ Foster Parent ☐ Guardian ☐ Step Parent ☐ Other
Father's Name: _____ _____ Last First	Check One: ☐ Legal Parent ☐ Foster Parent ☐ Guardian ☐ Step Parent ☐ Other

Marital Status:
Check one ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other

Address: _____ _____	Who has physical custody? _____ Guardianship Papers Present ☐ Yes ☐ No

Home Phone # _____ Email address:	Mother's Cell # _____ Mother's Work #	Dad's Cell # _____ Dad's Work #

Siblings

Childs' Name	Age:	Grade:
Childs' Name	Age:	Grade:
Childs' Name	Age:	Grade:

Copies of report cards, school reports, etc. can be mailed to: _____

Is there a custody or parenting plan in effect? ☐ Yes ☐ No
Are there restrictions on the non-custodial parent contact with the student at school? ☐ Yes ☐ No
Is there a restraining order in effect? ☐ Yes ☐ No *If yes, legal papers must be on file with the school.*
Restraining order is against: _____

Non-Custodial Parent: _____
Address: _____
_____

Person to Notify, other than Parents, in case of Emergency:		
Relationship to Child:	Home Phone #	
Work Place:	Work Phone #	Cell #

Health Information

Health Concerns

Check all that apply:

- ☐ Allergies (What kind?) _____
- ☐ Epi-pen (Does your child have one in school?) ☐ Yes ☐ No
- ☐ Asthma
- ☐ Inhaler (Does your child have one in school?) ☐ Yes ☐ No
- ☐ Heart
- ☐ Seizures
- ☐ Diabetes (Does your child take insulin?) ☐ Yes ☐ No
  (If yes, please explain) _____
- ☐ Other: _____

Medications:	
Doctor:	**Doctor's Phone # :**

I certify that this information is true and correct.

_____

Signature of Parent/ Guardian

RESIDENCY INFORMATION FORM

This questionnaire is in compliance with the McKinney-Vento Act, U.S.C. 42 § 11432(a). Your answers will help the administrator determine residency documents necessary for enrollment of your student(s).

Student _____ Parent/Guardian _____

School _____ Phone/Pager _____

Age _____ Grade _____ D.O.B. _____

Address _____ City _____

Zip Code _____ Is this address Temporary or Permanent?

Please choose which of the following situations the student currently resides in (you can choose more than one):

_____ House or apartment with parent or guardian
_____ Motel, car, or campsite
_____ With friends or family members (other than parent/guardian)
_____ Shelter or other temporary housing

If you are living in shared housing, please check all of the following reasons that apply:

_____ Economic situation
_____ Temporarily waiting for house or apartment
_____ Provide care for a family member
_____ Living with boyfriend/girlfriend
_____ To enable child to attend XXXX Schools
_____ Loss of employment
_____ Parent/Guardian is deployed
_____ Other (Please explain)

Are you a student under the age of 18 and living without your parents or guardians? Yes No

Residency and Educational Rights

Students who are in temporary, inadequate, and homeless living situations have the following rights:

1) Immediate enrollment in the school they last attended or the school in whose attendance area they are currently staying even if they do not have all of the documents normally required at the time of enrollment;
2) Access to free meals and textbooks, Title I and other educational programs, and other comparable services including transportation;
3) To attend the same classes and activities that students in other living situations also participate in without fear of being separated or treated differently due to their housing situations.

Any questions about these rights can be directed to the local McKinney-Vento Liaison at (XXX) XXX-XXXX or the State Coordinator at (800) 833-2199.

By signing below, I acknowledge that I have received and understand the above rights.

_____

Signature of Parent/Guardian/Unattached Youth *Date*

_____

Signature of McKinney-Vento Liaison *Date*

Notice and Consent to Share and Use Immunization and Demographic Information with local public health and the electronic statewide Public Health Data System

Immunization information on _____ will be shared with local public health departments and entered into an electronic data system, the Montana Public Health Data System (PHDS). The intent of an electronic immunization registry is to provide a complete and permanent immunization record for your child.

Your signature is your consent that the immunization information for your child may be shared with the local public health department and entered into the PHDS.

_____ Date_____

Parent/Guardian's Signature

Dear Parent/Guardian:

Wibaux Public School conducts vision, hearing, & dental screenings throughout the year. The purpose is to gather information on the health needs of children throughout Montana. Results will be kept confidential and your child will not be named in any survey report.

If you <u>do not</u> wish for your child to have a dental, vision, or hearing screening, please check NO below and return the form to the school.

Health Screening

If you <u>do not</u> want your child to have health screenings, please complete the form below and return it to the school.

Child's Name: _____ Child's Teacher: _____

_____ NO, I do not want my child to receive a dental screening

_____ NO, I do not want my child to receive a vision screening

_____ NO, I do not want my child to receive a hearing screening

_____ _____

Parent/Guardian Signature Date

Wibaux Public Schools

CONSENT TO RELEASE PHOTO/IMAGE

Dear Parent/Guardian:

During the current school year, your child/children's image/photograph or work may be included in a classroom or school project that could be used in one of the following ways:

- Used as a sample project/activity on CD's created by Wibaux Public School for use in workshops and student classrooms
- Posted on a school bulletin board or in classrooms
- Posted on the school website
- Appear on videotape made during a student presentation of their project, or in or videotapes demonstrating computer multimedia in general
- Used in a printed publication such as a newspaper or magazine

While your child/children's name may accompany the photo, no last name or address will be included with your child's picture when publishing on the Web.

Please sign the release form below and return this sheet to your child's school. Your permission grants us approval to publicize without prior notification and remains in effect until revoked. Thanks!

Release Form

_____I/We **DO NOT** give permission for_____'s
Child/Children's full name
image/photograph or work to be used a described above.

Parent/Guardian Name_____
Please print clearly

Parent/Guardian Signature _____

Address_____

City, State, Zip Code_____

Phone Number_____

Please return this form to the Wibaux Elementary or High School Office.

DATE_____

Montana Authorization to Carry and Self-Administer Medication

For this student to carry and self-administer medication on school grounds or for school sponsored activities, this form must be fully completed by the prescribing physician/provider and an authorizing parent, an individual who has executed a caretaker relative educational authorization affidavit, or legal guardian.

Student's Name:_____ School:_____
Sex: (Please circle) Female/Male City/Town: _____
Birth Date: _____/_____/_____ School Year: _____(Renew each year)

Physician's Authorization:
The above named student has my authorization to carry and self administer the following medication:
Medication: (1)_____ Dosage: (1) _____

(2) _____ (2) _____

Reason for prescription(s): _____
Medication(s) to be used under the following conditions: _____

_____

I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication on his own with out school personnel supervision. I have provided a written treatment plan for managing asthma, severe allergies, or anaphylaxis episodes and for medication use by this student during school hours and school activities.

_____ _____ _____
Signature of Physician Physician's Phone Number Date

Backup Medication – The law provides that if a child's health care provider prescribes "backup" medication to be kept at the school, it must be kept in a predetermined location, known to the child, parent, and school staff.

The following backup medication has been provided for this student: _____

For Completion by Parent, an individual who has executed a caretaker relative educational authorization affidavit, or Guardian

As the parent, individual who has executed a caretaker relative educational authorization affidavit, or guardian of the above named student, I confirm that this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she has demonstrated to me that he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used an auto-injectable epinephrine, he/she understands the need to alert an adult that emergency medical personnel need to be called. If he/she has used his/her asthma inhaler as prescribed and does not have relief from an asthma attack, he/she is to alert an adult.

I also acknowledge that the school district or nonpublic school may not incur liability as a result of any injury arising from the self-administration of medication by the student and that I shall indemnify and hold harmless the school district or nonpublic school and its employees and agents against any claims, except a claim based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.

I agree to also work with the school in establishing a plan for use and storage of backup medication if prescribed, as above, by my child's physician. This will include a predetermined location to keep backup medication to which my child has access in the event of an asthma or anaphylaxis emergency.

Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

I understand that in the event the medication dosage is altered, a new "self-administration form" must be completed, or the physician may rewrite the order on his prescription pad and I, the parent/guardian, will sign the new form and assure the new order is attached.

I understand it is my responsibility to pick up any unused medication at the end of the school year, and the medication that is not picked up will be disposed of.

Parent/Guardian, caretaker relative Signature: _____ Date: _____

(Original signed authorization to the school; a copy of the signed authorization to the parent/guardian and health care provider)