ELDON R-I SCHOOLS ENROLLMENT INFORMATION

Date_____

Race: (please check) White_____Black_____Hispanic_____Indian_____Asian_____Other_____

Student's Name: _____**Birthdate:**_____ **Age:**_____

Address: _____**City:**_____**ZipCode**_____

IF PO BOX is used, please list actual street address above: PO BOX #_____

Home Phone #: _____ **Cell #:** _____**E-mail Address:** _____

Grade _____ **Social Security #:** _____ Male _____ **Female** _____

Parent/Guardian (in home) or whom you are living: **Are you a registered voter? YES NO**

Parent 1 Information: _____ **Relation:** _____

Employer: _____ **Work #:** _____ **Cell #:**_____

Parent/Guardian 2 Information _____ **Relation:** _____

Employer: _____ **Work #:** _____ **Cell #:** _____

Parent/Guardian E-mail Address: _____

Please list all siblings in Eldon Schools and their ages: _____

Are there currently any court orders dealing with custody or visitation? YES NO

IF YES, please provide the school with a copy. We CANNOT honor without documentation.

Emergency Contacts:

1.Name_____ **Relation:**_____**Phone #:**_____**Cell:**_____

2.Name_____ **Relation:**_____**Phone #:**_____**Cell:**_____

Name of Parent out of the home (if applicable): _____**Relation:** _____**Home #:**_____

Employer: _____ **Work #:**_____ **Cell #:** _____

Would this parent like a grade card sent to them? **YES** **NO** **If yes please provide address**

Previous school attended (name of school in what State): _____

Previous school address: _____ Phone #: _____

Circle the county in which you live: MILLER MORGAN MONITEAU

Circle the district in which you live: ELDON R-I HIGH POINT OTHER

Does the student use a language other than English? YES NO If YES, what language? _____

Is a language other than English used in the home? YES NO If YES, what language? _____

What is the student's Native language?_____

Are you currently living in a temporary residence due to loss of permanent housing (e.g. motel, hotel, car, shelter)? ***YES NO***

Has your family moved within the past 3 years to seek or obtain temporary or seasonal agricultural or food processing work? ***YES NO***

_____My signature below signifies I give permission for my child to go on school or classroom trips during the elementary school years. I will be responsible to notify the school, in writing, if I want to change my position on my child attending field trips during his/her elementary years.

_____I give permission for any local newspaper staff to photograph my child and/or to publish his/her work.

_____My signature below signifies if I cannot be reached in the event of an emergency, I give consent for the school to obtain, through a physician or hospital of its choice, such medical care as is reasonably necessary for the student. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

_____May take over the counter medications (generic Tylenol, cough drops, antacid, oral care, basic first aid).

Is child involved in (check all that applies):

Special Ed. classes _____ Speech _____ Title I Reading ____ Gifted ___ 504 Plan ____

I VERIFY THAT ALL ENROLLMENT INFORMATION IS CORRECT.

Parent Signature _____ **Date** _____

Two sided please turn over

Eldon R-1 School District – Health Services
Student Health Information
2011-2012

Student Name _____ **Teacher** _____ **Grade** _____

Regular or Emergency Medications Your Child Is Taking
(at home) _____

(at school) _____

I request that you give over the counter medication to my child during the school year in accordance with the Board Policy. I authorize the school nurse or designee to give my child medication. I will not hold the school staff responsible for any undesired reaction that may occur from the medication. (Examples of non-prescription medication to be given with parent permission are: non-aspirin pain relievers including Acetaminophen, Ibuprofen, Tylenol, sore throat spray, antacid, antibiotic ointment, hydrocortisone cream, calamine lotion, throat lozenges, topical anti-sting treatments and generic substitutes.

THE SCHOOL NURSE MAY ADMINISTER THE FOLLOWING SCREENING:
As Appropriate
Height, Weight, Vision, Hearing, Blood Pressure and Scoliosis

I hereby give my permission for the Eldon Schools to seek medical attention at my expense with the understanding that the school will make every effort to contact a parent/guardian emergency number prior to transporting my child. Transportation may be by private vehicle or ambulance as deemed necessary by the Nurse or Principal. I authorize personnel of the Eldon Schools to disclose/obtain records with the appropriate physician. The purpose or need for such disclosure is to facilitate and coordinate services. I understand the information disclosed will remain confidential.

It is my understanding that my signature allows all of the above information and treatment to be administered to my student.

Parent Signature _____ **Date** _____

Please mark below if your child has any of the following:

___ Asthma, ___Diabetes, ___ Seizures, ___ Severe Allergies, ___ Heart Condition, ___ ADHD, ___ADD
___ Hearing problem, ___ Vision problem, ___ Seasonal Allergies, ___ Other Medical Condition

EXPLAIN _____

List **All** Child's **Medication Allergies** _____

List **All** Child's **Food Allergies** _____

Physician and Hospital of Choice _____

1. Any medication that is sent to school with a student must in the original container with the students name on it.
2. Medication sent to school with a student must be accompanied by a signed and dated note from the parent/guardian requesting the medication to be given.
3. It is recommended that a small container of medication be sent to school.
4. All medications must be given to the school nurse as soon as the student arrives at school.
5. Please make sure the medication is age appropriate.

Permission is granted during the current school year only. All permission requests will need at least annual renewal, **EXCEPT** for grades 9-12. Signing this for 9th graders gives permission through 12th grade.

If medication brought to school during the school year is not picked up by the week after school is out then it will be destroyed in the presence of another staff member and documented.

Eldon R-1 School District – Health Services
Authorization for Medication

The following section is to be completed by the PARENT:

School _____ Grade _____

Student Name _____

Physician Name _____

Physician Address _____

Physician Phone Number _____ Fax # _____

___ **I request that my child be assisted in taking the medications listed below.**

___ **I give my permission for my child to carry and self administer the medications listed below.**
I acknowledge that the district and its employees or agents will incur no liability as a result of any injury arising from the self-administration of such medication.

_____ _____ _____
Parent Signature Date Phone Number

The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is to be given _____

Name of Medication _____

Dosage and Form _____

Time to be Given _____

If medication is to be given "***as needed***" describe indicators _____

Significant Side Effects _____

Length of time this medication is recommended _____

How soon can the medication be repeated _____

This student has been taught to self medicate and I recommended that it to be self carried.

_____ _____ _____
Physician Signature Date Phone Number