SHAWNEE HEIGHTS
UNIFIED SCHOOL DISTRICT 450

I, _____, do hereby acknowledge receipt of the student handbook for the ___2020-2021_____ school year. I have read this handbook, and I understand the contents. Further, I understand:

This handbook contains the yearly-required notification on the following issues:

- Nondiscrimination
- Family Educational Right to Privacy Act
- Directory Information
- Drug Free Schools and Communities Policy
- Inoculations
- Acceptable Use of Computer Policy

As a condition of enrollment, I am required to abide by all regulations contained in the handbook as well as other policies established by the board of education.

If I choose not to abide by the regulations contained in this handbook, any other policy established by the board of education, or any reasonable request by school authorities, disciplinary action may be imposed, up to and including expulsion from school.

Date_____Signature of Student_____
(*Student Signature required starting @ 5th Grade*)

Name of Student's Teacher_____ Grade_____

Date_____Signature of Parent_____

GF-039
6/2017

HEALTH INFORMATION

Dear Parent,

The following health related items must be on file for each child to attend class in Shawnee Heights U.S.D. 450 school district and **must be turned in before the first day of school.**

Immunizations: The state law requires that all students be fully immunized prior to school entry. Proof of immunization must be provided to the health staff. Proof would include a copy of immunization booklet, document signed by a physician, or a copy of health department records. It is the responsibility of the parent/guardian to provide this information.

The superintendent may exclude any student who fails to provide the documentation required by law from school until statutory requirements are satisfied. Notice of exclusion shall be given to the parents/guardians as prescribed by law.

Physical Exam: Children entering a Kansas school for the first time who are 8 years old or younger are required by state law to have a physical exam and/or health assessment form completed and on file in the health room at school. Most doctors will fill out a physical form if your child has been seen in the past year. You may not need to make an additional appointment. Please check with your doctor.

To facilitate this process, we are asking parents to return the completed required forms and a **copy** of immunizations prior to round up. Please feel free to include this information with your enrollment forms and return them to the school office any time before round up.

If your child needs additional immunizations, a schedule of times and locations has been attached for your convenience. The Shawnee County Health Agency also offers physical exams and/or health assessments. To schedule an appointment please call their office at 368-2000.

Kara Kalous, RN
School Nurse
785-730-5310
kalousk@usd450.net

IMMUNIZATIONS SCHEDULE for
SHAWNEE COUNTY HEALTH AGENCY
1615 SW 8th Ave 785-368-2180
Monday, Thursday, Friday 8:00 am – 11:00 am & 1:00 – 4:00 pm
Tuesday 10:00 am – 1:00 pm and 3:00 pm – 6:00 pm
Wednesday 8:00 am – 11:00 am, and 2:00 pm – 4:00 pm

SHAWNEE HEIGHTS UNIFIED SCHOOL DISTRICT 450

Health History

School Year 2020-2021 Grade_____ Date_____

This information will be held in confidence by the school personnel who handle it. It is important that the questions on BOTH sides of this form be answered completely and accurately.

Student's Name _____ Male / Female Birthdate _____

Parent/Guardian Name _____ Home Phone _____

Mother's Work Phone _____ Father's Work Phone _____

Mother's Cell Phone _____ Father's Cell Phone _____

If a parent cannot be reached at any of the above phone numbers who should we contact in an emergency?

Name _____ Relationship to Student _____ Phone _____

Is student new to this school district? ☐ Yes ☐ NO
If yes, what school and school district did student last attend? _____

For the safety and well being of your child, the medical information will be released to all school personnel working directly with your child.

ALLERGY TO MEDICATION: ☐ NO ☐ YES IF YES, PLEASE LIST_____

ALLERGY TO FOOD: ☐ NO ☐ YES IF YES, PLEASE LIST_____

ALLERGY TO OTHER, PLEASE LIST _____

EMERGENCY PRODEDURE NEEDED _____

Please check any current health concerns:

- ☐ Vision
  - ☐ Wears glasses
  - ☐ Wears contacts
- ☐ Hearing
  - ☐ Wears hearing aids
- ☐ Frequent Ear Infections
- ☐ Diabetes
- ☐ Speech
- ☐ Heart
- ☐ High Blood Pressure
- ☐ Migraines
- ☐ Urinary Problems
- ☐ Degenerative Disease (Arthritis, MS, MD, etc.)
- ☐ Attention Deficit (ADD)
- ☐ Attention Deficit/Hyperactivity (ADHD)
- ☐ Seasonal Allergies
- ☐ Eczema
- ☐ Seizure Activity
- ☐ Asthma
- ☐ Other, Please List:
  _____
  _____
  _____

Does above health concern require special attention at school? ☐ NO ☐ YES
Please explain_____

_____

What medication(s) is your student on?_____

_____

Physician Preference: _____ Hospital Preference:_____

Last Tetanus Booster: _____ Medical Insurance: _____

Known Medical Problems:_____

TURN FORM OVER FOR ADDITIONAL INFORMATION REQUIREMENTS

SHAWNEE HEIGHTS UNIFIED SCHOOL DISTRICT 450

PARENTAL AUTHORIZATION FOR EMERGENCY MEDICAL CARE AND TREATMENT

Student's First Name | Student's Last Name | Student's Date of Birth

(I) (We) hereby appoint any Principal, Assistant Principal, or School Administrator of Shawnee Heights School District #450 or his or her designee, as a person who, during my/our absence or unavailability, who shall be authorized to consent to or for all medical and/or surgical care and treatment and/or special procedures (including byway of illustration and not limitation, administration of anesthesia, blood transfusions, diagnostic tests, x-rays, etc.) which may reasonably be required during my/our absence or unavailability for our child above named.

Without in any manner limiting the foregoing appointment and/or authorization, if circumstances reasonably permit, I/we would like to have our physician consulted in connection with such medical and/or surgical treatment and/or special procedures, said physician being:

Name of Physician | Physician's Address | Telephone No.

(I) (We) further state that any hospital or medical care provider or member of the healing arts providing medical or surgical services to any child named above may rely upon this Consent of Authorization executed by any of the above named appointees with the same force and effect as if the same was personally executed by (me) (us).

(I)(We) give consent for immunization information to be released to the Kansas Immunization Program (KIP).

This Consent and Authorization shall include and extend to all matters for which consent or authorization is required by any hospital, medical care provider or member of the healing arts profession. In consideration of the services which are rendered to my child named above, pursuant hereto, (I) (We) agree to pay for all such services in the same manner and to the same extent as if the same had been personally authorized. This Authorization shall be effective with Shawnee Heights U.S.D. #450 unless and until the same is revoked in writing, (or by written notice).

IMPORTANT REQUIREMENT

IN WITNESS WHEREOF, (I) (We) have hereunto set our hands this

_____day of_____, 20_____.

_____

Signature of Father and/or Mother

If the child or children is under a guardianship, then this form must be signed by such guardian and the name of the Court and the Case number appointing the guardian must be included.

Guardian Signature | Court | Case Number

SHAWNEE HEIGHTS UNIFIED SCHOOL DISTRICT 450

ANNUAL NOTICE OF AUTHORIZED STUDENT DATA DISCLOSURES

In accordance with the Student Data Privacy Act and board policy IDAE, student data submitted to or maintained in a statewide longitudinal data system may only be disclosed as follows. Such data may be disclosed to:

- The authorized personnel of an educational agency or the state board of regents who require disclosures to perform assigned duties; and
- The student and the parent or legal guardian of the student, provided the data pertains solely to the student.

Student data may be disclosed to authorized personnel of any state agency, or to a service provider of a state agency, educational agency, or school performing instruction, assessment, or longitudinal reporting, provided a data-sharing agreement between the educational agency and other state agency or service provider provides the following:

- purpose, scope and duration of the data-sharing agreement;
- recipient of student data use such information solely for the purposes specified in agreement;
- recipient shall comply with data access, use, and security restrictions specifically described in agreement; and
- student data shall be destroyed when no longer necessary for purposes of the data-sharing agreement or upon expiration of the agreement, whichever occurs first.

  *A service provider engaged to perform a function of instruction may be allowed to retain student transcripts as required by applicable laws and rules and regulations.

Unless an adult student or parent or guardian of a minor student provides written consent to disclose personally identifiable student data, student data may only be disclosed to a governmental entity not specified above or any public or private audit and evaluation or research organization if the data is aggregate data. "Aggregate data" means data collected or reported at the group, cohort, or institutional level and which contains no personally identifiable student data. The district may disclose:

- Student directory information when necessary and the student's parent or legal guardian has consented in writing;
- directory information to an enhancement vendor providing photography services, class ring services, yearbook publishing services, memorabilia services, or similar services;
- any information requiring disclosure pursuant to state statutes;
- student data pursuant to any lawful subpoena or court order directing such disclosure; and
- student data to a public or private postsecondary educational institution for purposes of application or admission of a student to such postsecondary educational institution with the student's written consent.

As the parent or legal guardian of _____, I acknowledge that I have been provided with notice of authorized student data disclosures under the Student Data Privacy Act.

Name of Student's Teacher _____ **Grade**_____

_____ _____

Parent Signature **Date**

SHAWNEE HEIGHTS
UNIFIED SCHOOL DISTRICT 450

Dear Parents:

Our school will soon be administering the *Kansas Communities That Care Student Survey**. This survey is taken by 6th, 8th, 10th and 12th grade students statewide. I believe this survey is a valuable tool to help us understand how students perceive things like substance use and bullying. It gives us insight into the problems students face and shows what we can do to help them succeed. The information is essential to local and state grant funding and to planning effective prevention programs in our school and community.

The survey is available to view at www.kctcdata.org/Documents/ctc_survey_.pdf. You may also be interested to know the following:

1. **It is completely anonymous.** Students will not be asked for their names on the questionnaire, nor will anyone be able to connect any individual student with his/her responses. School staff will not see any one student's responses, but only summaries of results. To further guarantee anonymity, results will not be reported on any particular question without sufficient response from enough students.

2. **Participation is entirely voluntary.** Your child may decline to participate in the survey, or may simply skip any particular question they do not wish to answer.

3. **Annual participation is important.** Even if your child has participated in previous surveys, annual data is extremely helpful in determining the effectiveness of previous efforts and changes in program areas.

I hope you will allow your child to participate. Please check the appropriate box below. Thank you in advance for your cooperation.

Sincerely,

PRINCIPAL

Please check one:

☐ **Yes, I give permission** for my child to participate in the *Kansas Communities That Care Student Survey*.
☐ **No, I do not** give permission for my child to participate in the *Kansas Communities That Care Student Survey*.

_____	_____
Signature of Parent/Guardian	Printed Parent/Guardian Name
_____	_____
Printed Name of Child	Date

*The survey is provided by the Kansas Department for Aging and Disability Services Behavioral Health Services and administered by the Southeast Kansas Education Service Center Grants and Evaluation Department.