



***"SNEAK PEEK"***

**at Shawnee Heights Elementary  
on Monday, August 13, 2018, 5:30-7:30 p.m.**

*Come and see your classroom, meet your teacher, see your new classmates and  
bring the school supplies you have!*

***PARENT INFORMATION NIGHTS***

**Wednesday, August 22, 2018 for:**

ECSE (Preschool) and Kdg Parents – 5:15 pm  
First and Second Grade Parents – 6:15 pm

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**Thursday, August 23, 2018 for:**

Third and Fourth Grade Parents – 5:15 pm  
Fifth and Sixth Grade Parents – 6:15 pm



## **S.H.E.S. 2018 CARNIVAL**

### **Saturday, Sept. 15th**

Mark your calendars for a fun-filled day on **Saturday, September 15, 2018** from 1:00-4:00p.m. for the SHES Annual Carnival! Our carnival provides a safe and fun environment for SHES students and their families. Any profits from the event are donated to SHES PTO.

As always, we will have many exciting rentals as well as lots of new games and events! Kiddie Korner will provide shade and fun for the younger crowd and don't miss BINGO inside the gym! The SHES redemption center is known throughout the community for having some of the best and exciting prizes.



I, \_\_\_\_\_, do hereby acknowledge receipt of the student handbook for the 2018-2019 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 @ 5<sup>th</sup> Grade)

Name of Student's Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent \_\_\_\_\_

# 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, August 20, 2018.**

**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](mailto:kalousk@usd450.net)

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|---|
| <p><b>IMMUNIZATIONS SCHEDULE for</b><br/><b>SHAWNEE COUNTY HEALTH AGENCY</b><br/>1615 SW 8<sup>th</sup> Ave 785-368-2180<br/><b>Monday, Thursday, Friday</b> 8:00 am – 11:00 am &amp; 1:00 – 4:00 pm<br/><b>Tuesday</b> 10:00 am – 1:00 pm and 3:00 pm – 6:00 pm<br/><b>Wednesday</b> 8:00 am – 11:00 am, and 2:00 pm – 4:00 pm</p> |
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# Health History

School Year 2018-2019 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:

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

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: \_\_\_\_\_





**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).



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





## **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**



Dear Parents:

Our school will soon be administering the *Kansas Communities That Care Student Survey*\*. This survey is taken by 6<sup>th</sup>, 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> 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](http://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

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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.