Mullanphy – Botanical Garden ILC

Student Information Form

___ **Please check if this is a returning student.**

___ **Please check if the information is the same as 22/23**

STUDENT NAME

(last)_____(first)_____(middle)_____

HOME ADDRESS_____

CITY/STATE_____ Zip Code_____

HOME PHONE_____

Birth Date ____/____/_____ Race_____ Gender_____

Mother:_____ **Father:**_____

Cell :_____ Cell:_____

Employer:_____ Employer:_____

Work #:_____ Work #:_____

Email:_____ Email:_____

Emergency Contacts (other than above)

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Pick Up Authorization **Students will only be released to those listed** (must have valid ID and be 18 years of age):

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Siblings Attending Mullanphy

Name_____Relationship_____ Grade_____

Name_____Relationship_____ Grade_____

Name_____Relationship_____ Grade_____

Name_____Relationship_____ Grade_____

Medical Information: Primary Care Physician_____ Phone_____

Parent Signature_____ **Date**_____

MULLANPHY
Explore. Learn. Grow. Together.

Mullanphy-Botanical Garden ILC

Mullanphy Family Agreement

Attending a Magnet School is a privilege, and we are very happy to invite your child to join the Mullanphy Family! There are behavior and attendance expectations that come along with your acceptance to our school. Students who come late to school or leave early miss out on important routines and instruction of the day. Late arrivals and early dismissals also reduce our daily attendance average which is reported to the district and state. It is very important your child arrives by 9:05 daily to enter class with their peers and stays until 3:45, which is dismissal time. Regular daily attendance is also expected. Please plan appointments on days off or after school hours when possible. Finally, learning and safety are our highest priorities at Mullanphy. Respectful behavior is expected at all times with support from teachers and family. Regular violations of the 4 above expectations can lead to a transfer from Mullanphy to your neighborhood school.

By working together to ensure the above Mullanphy expectations are met, our school will be an exemplar place for your child to learn and grow!

Family Agreement

Child's Name_____

Parent's Name_____

I understand and agree that chronic violations to above family expectations can lead to a transfer to my neighborhood school.

Parent Signature_____ Date_____

Mullanphy-Botanical Garden ILC
Pre-Kindergarten – 5th Grade

SCHOOL-PARENT COMPACT

2022 - 2023

The Mullanphy Staff welcomes parents and families as partners in their children's education. By working closely together, we can ensure a positive and successful school year.

Raising the Bar for Students!

Teacher Responsibilities (We Will):

- Actively plan and prepare lessons for every student's individual needs.
- Cultivate a positive classroom environment for students.
- Ensure that the instruction communicated clearly and accurately and engages students in learning.
- Communicate consistently with parents and/or guardians about the social and academic progress of students.
- Provide opportunities for parents to participate in decisions about the education of their child.

Parent and Family Responsibilities (I Will):

- Make sure that my child is on time, in school uniform, and strive for 100 percent attendance.
- Establish a time and place for homework and work with my child to get it handed in the next day.
- Attend parent conferences, student support meetings, family activity nights, and school activities.
- Participate, as appropriate, in decisions relating to my child's education.

Student Responsibilities (I Will):

- Come to school in uniform each day ready to learn and do my best!
- Do my homework every day and ask for help when I need it.
- Read at least 20 minutes every day outside of school time.
- Give my parent or guardian all papers and information sent home with me from the school.
- Follow all classroom and schoolwide rules.
- Exhibit Mullanphy Lion's ROAR behavior throughout the school as well as in my classroom (refers to the R.O.A.R MATRIX).

_____ _____ _____

(Teacher) (Parent/Guardian) (Student)

_____

(Date)

SAINT LOUIS
PUBLIC SCHOOLS

TECHNOLOGY USAGE

District network/Internet access and assignment of e-mail account

Student Agreement

I have read the St. Louis Public School District Technology Usage Policy, administrative regulation, and guidelines and agree to abide by their provisions. I understand that violation of these provisions may result in disciplinary action taken against me, including but not limited to suspension or revocation of my access to district technology, and suspension or expulsion from school.

I understand that my use of the District's technology is not private and that the school district may monitor my use od district technology, including but not limited to accessing browser logs, e- mail logs, and any other history of use. I consent to teacher-monitoring of my activities on the District network or the Internet. I consent of district interception of or access to all communications I send, receive or store using the District's technology resources, pursuant to state and federal law.

Student Signature Printed Name Date

X

Parent Signature Printed Name

MEDIA RELEASEFORM

I understand the photograph(s) or video or audio recording(s) taken of my child by agents, employees or representatives of the Saint Louis Public Schools (hereinafter called "SLPS") shall be used in connection with the SLPS's dissemination of information by its public service and academic programs to the general public.

I hereby irrevocably authorize the SLPS to copy, exhibit, publish or distribute any and all such images and audio of my child or wherein he or she shall appear, including composite or artistic forms and media, for purposes of publicizing SLPS programs or for any other lawful purpose. In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my child's likeness appears.

I hereby hold harmless and release and forever discharge the SLPS from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my or my child's behalf, may have by reason of this authorization.

Child's Legal Name Birthdate

I hereby certify that I am the parent or guardian of, the minor named above, and do hereby give my consent without reservations to the abovementioned.

X

Parent Signature Printed Name

ST. LOUIS PUBLIC SCHOOLS
FIELD EXPERIENCE PERMISSION SLIP

MULLANPHY ELEMENTARY SCHOOL **August 2022 - May 2023**

GRADE(S): PreK - 5th *ROOM#* _____

DAY: Monday- Friday *DATE:* August 22, 2022- June 2, 2023

ACTIVITY: Investigations connected to the curriculum emphasis of mathematics, science and or technology

DEPART FROM SCHOOL: any time during the school day

RETURN FROM SCHOOL: any time during the school day

PERSON(S) IN CHARGE: MULLANPHY - BOTANICAL GARDEN ILC STAFF

1. *I have been informed of the details of this educational field experience.*
2. *My child has my permission to participate in this supervised field experience.*
3. *I agree to instruct my child to obey all rules, regulations and instruction given by teachers, and/or authorized school personnel. I further agree that no teacher or authorized school personnel shall be held responsible or liable for injuries or other mishaps caused by my child's deliberate disobedience of rules, regulations or instructions.*
4. *This field experience is considered as school work and will be conducted as a regular class.*

I give permission for _____ to take the field experience(s) ***to various institutions within the St. Louis metropolitan area related to the curriculum***.

Your signature below indicates that you have read and agreed to the above and that we have your permission to take your child on these field experiences.

_____
Parent or Guardian's Signature

_____ _____
Home Address *Home Phone*

_____ _____
Cell Phone *Work Phone*

Other person to contact in an emergency: _____

_____
Contact Phone #

Other person to contact in an emergency: _____

_____
Contact Phone #

Student and Parent(s)/Legal Guardian(s) Affidavit

Dear Students and Parent(s)/Legal Guardian(s):

The St. Louis Public Schools' is committed to provide a safe school environment. Please review this Parent Information Guide and Student Code of Conduct in order to help us achieve this goal. Please sign the affidavit below-and return to your child's classroom teacher. This document acknowledges your receipt of this information for which every St. Louis Public School student is responsible. Thank you for your cooperation in helping make our schools safe places for learning.

Purpose of the Student Code of Conduct

- Create a consistent set of expectations for student behavior
- Reinforce positive behavior and provide students with opportunities to develop appropriate social skills
- Outline interventions and consequences for students who engage in inappropriate behavior
- Explain the rights and responsibilities of all members of the school community
- Engage students in a safe, positive and supportive learning environment

Student Pledge

- I pledge to be in attendance and on time for class everyday.
- I pledge to be safe, responsible, and respectful and prepared.
- I pledge to be a problem solver.
- I pledge to work hard, do my best, and be proud of myself.
- I pledge to be engaged in my child's learning.

Parent/Guardian Pledge

- I pledge my child will be in attendance and on time for class every day.
- I pledge to teach my child to be safe, responsible, respectful, and prepared.
- I pledge to be a responsible advocate for my child.
- I pledge to be engaged in my child's learning.
- I pledge to support my child in following the Student Code of Conduct.
- By signing this pledge, I understand and accept the responsibility of the Student Code of Conduct, for as long as I am a parent in the Saint Louis Public School District.

Student Signature: _____

Date: _____

Parent/Legal Guardian Signature: _____

Date: _____

SAINT LOUIS PUBLIC SCHOOLS

Student Health Registration Form / *RETURN TO SCHOOL NURSE*

This questionnaire is designed to aid the school nurse in anticipating any health concerns that might affect your child's safety or learning.

Student Name _____ Grade ____ Sex ____ Date of Birth _____
LAST FIRST MI

MEDICAL

Does your child have a doctor or nurse practitioner? Yes ___ No ___
Name of child's doctor or nurse practitioner _____ Phone # _____
In the past 12 months, did you have problems obtaining medical care for your child? Yes ___ No ___

DENTAL

Does your child have a dentist? Yes ___ No ___
Name of child's dentist _____ Phone # _____
Did your child receive a dental exam in the last 12 months? Yes ___ No ___
Describe the condition of your child's teeth? Good ___ Fair ___ Poor ___
In the past 12 months, did you have problems obtaining dental care for your child? Yes ___ No ___

INSURANCE

Does your child have medical insurance coverage? Yes ___ No ___ Name of Provider _____
Does your child have dental insurance coverage? Yes ___ No ___ Name of Provider
Does Medicaid (MO HealthNet) insure your child? Yes ___ No ___

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has:

___Asthma ___Seizure disorder ___Bleeding disorder ___ADD/ADHD
___Diabetes ___Bone/muscle disease ___Skin condition ___Learning disability
___Heart condition ___Mental health condition (i.e. depression, anxiety, eating disorder) ___Other_____

Does your child experience any of the following?

___Nose bleeds ___Frequent ear aches ___Overweight for age ___Physical disability
___Poor appetite ___Frequent stomachaches ___Frequent headaches ___Fainting spells
___Tires easily ___Emotional concerns ___Underweight for age ___Other _____
Do any of the condition(s) limit/effect your child at school? _____

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes*___ No ___ Describe: _____

ALLERGIES

___Plants ___Animals ___Food ___Molds ___Drugs ___Bees ___ Other _____
Please describe the allergic reaction and the treatment for each checked allergy_____
_____
Do you plan for your child to receive school prepared meals? Yes___ No___
Will your child require food substitutions? Yes**___ No___

****The Medical Statement for Student Requiring Special Meals must be completed to allow food substitutions.**

MEDICATION

Does your child take any medication? Yes ___ No ___ If yes, name of medication(s) _____
Purpose_____ Will medication be needed at school? Yes*___ No___

If the answer to any of these questions is yes, please call to schedule a time to meet with the school nurse!

HEARING/VISION

Do you have concerns about your child's hearing? Yes___ No___ Does your child wear hearing aids? Yes___ No___
Do you have concerns about your child's vision? Yes___ No___ Does your child wear glasses or contacts? Yes___ No___

SPEECH/LANGUAGE

Do you have concerns about your child's speech and/or language? Yes___ No___
Do others have difficulty understanding your child? Yes___ No___ If yes, please explain_____
_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature _____ **Date** _____

SAINT LOUIS PUBLIC SCHOOLS

DEPARTMENT OF STUDENT SUPPORT SERVICES
OFFICE OF HEALTH SERVICES

AUTHORIZATION FOR ADMINISTERING MEDICATION TO STUDENT

The medication administration policy for students enrolled in the St. Louis Public Schools requires parents/guardians to read, understand, and complete the following before any medications can be given:

1. Sign an Authorization for Administering Medication to Student form at the beginning of each school year or anytime a medication is required during normal school hours.
2. Parent/guardian **must** deliver the medication to the school and present it to the school nurse or adult school staff designee. **Students may not transport medication to or from school that is to be administered by the school staff.**
3. Only bring medication to school in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law.

Date _____ School _____

Student _____ DOB _____ Room _____

TO BE COMPLETED BY PARENT:

I, _____, give permission for my child named above to
PRINT NAME – FIRST, MI, LAST
receive the medication(s) listed below as directed.

X _____
SIGNATURE OF PARENT/GUARDIAN HOME PHONE EMERGENCY PHONE

TO BE COMPLETED BY PRESCRIBING PHYSICIAN OR PRACTITIONER:

1. Diagnosis _____ Name of medication _____

Specific time(s) and dose(s) to be given at school _____

Beginning date _____ Ending date _____

Side effects _____

Restrictions _____

2. Diagnosis _____ Name of medication _____

Specific time(s) and dose(s) to be given at school _____

Beginning date _____ Ending date _____

Side effects _____

Restrictions _____

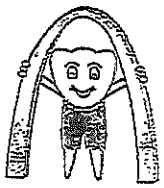
Printed Name of Prescribing Physician Signature of Prescribing Physician Date

Prescribing Physician's Phone Number Office Address

IN SCHOOL DENTAL CARE

Please complete sign & return to school. Questions? Please call (314) 872-3930

Taking care of your child's teeth is important to keep them healthy.



1. TELL US ABOUT YOUR CHILD

☐ To decline services, check here and complete "Student Name & "Birth Date" only.

Student Name _____ (PLEASE PRINT CLEARLY) FIRST NAME LAST NAME Male/ Female (CIRCLE ONE)

Student Birth Date ____/____/____ (MM/DD/YY) Race _____ (OPTIONAL) School _____

Teacher _____ District _____ Grade _____ Room# _____

Your Name _____ Relation to Student (CHECK ONE) ☐ Custodial parent ☐ Legal guardian

Address _____ City _____ State _____ Zip _____

Email _____ Phone( ) _____ 2nd Phone( ) _____

2. CHILD'S MEDICAL HISTORY

CHECK EACH CONDITION THAT APPLIES TO YOUR CHILD

Recent Dental Problems	Sickle Cell Anemia
Latex Allergy	Anemia/Fainting
Allergy to Medications/Other	Epilepsy/Seizures
Asthma or Wheezing	Liver Problems/Hepatitis
Behavioral Problems	Kidney Problems
Heart Problems/Murmur	HIV/AIDS
Rheumatic Fever	Cancer
Diabetes	Tuberculosis
Hemophilia/Bleeding Problems	Communicable Diseases

Notify us of any medical history changes. A thorough complete medical and dental history are important for a proper dental examination and evaluation.

List allergies _____

Name/phone # of child's physician _____

Use space below to provide additional details on your child's health, including current medical treatment, other significant past illnesses, alcohol & tobacco use (including smokeless). List current medications. Attach another page as needed.

_____

Approx. date of last dental visit. _____

3. DENTAL INSURANCE INFORMATION

CHECK ONE (Medicaid covers 100% of treatment)

☐ **CHILD HAS MEDICAID:** Missouri Medicaid Envolve United Health Care Liberty _____

Enter Child's ID Number HERE

☐ **CHILD HAS PRIVATE DENTAL INSURANCE**

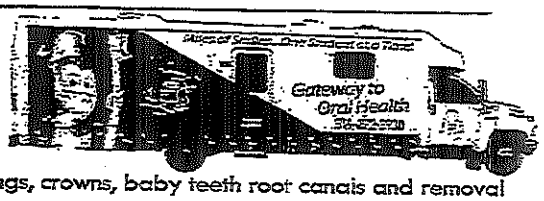
ID# _____ Group # _____

Name of Plan _____ Name of Insured Parent _____ Parent DOB _____

Parent SSN _____ Employer _____

Work Phone _____ Insurance Phone _____

☐ **CHILD IS UNINSURED**



4. CHECK TOTAL CARE OR PREVENTIVE CARE (Check only one)

Total Care

☐ Oral hygiene instructions, dental exams, x-rays, cleanings, fluoride, sealants, fillings, crowns, baby teeth root canals and removal of hopeless teeth.

Preventive Care only

☐ Oral hygiene instructions, dental exams, x-rays, cleanings, fluoride, and sealants.

By signing this consent form I give consent to the Gateway to Oral Health Health Foundation affiliated general dentists to provide dental care to my child at school without my presence unless I withdraw this consent. I also authorize and direct Gateway to Oral Health Foundation to bill and collect payment from any Medicaid, Insurance, or third party payer that covers the services provided to this patient. I agree to pay any portion of the charges not covered by the insurance. Photographs may also be taken and used as an educational/marketing tool for our program. Once signed, this consent form is valid for the entire school year.

SIGN HERE _____ _____ DATE

Print name _____ FOR YOUR PRIVACY PLEASE FOLD & SECURE

Gateway to Oral Health Foundation
2211 Olive Street, Suite 300, St. Louis, MO 63103

Kids Vision for Life St. Louis

Grades K-12*!
EYE EXAM and GLASSES for your child at NO COST
*K-12 in selected school districts

www.kidsvisionforlifestlouis.com

If your child does not pass his/her vision screening, they qualify to receive an eye exam from a Kids Vision for Life St. Louis licensed optometrist and a pair of prescription glasses at NO COST.

If needed, I want my child to get an eye exam and glasses at NO COST.

Student's Name _____ Student's Date of Birth _____

Medicaid ID Number _____ Gender: M F

School Name _____

I have reviewed a copy of "Kids Vision for Life St. Louis Media Release Form (Minors)" *(refer to back of form)* pertaining to Kids Vision for Life St. Louis' creation and distribution of media regarding the Kids Vision for Life St. Louis (KVFL) program.

I ☐ **DO** consent to KVFL producing and distributing media of my child solely for the promotion of KVFL.
I ☐ **DO NOT** consent to KVFL producing and distributing media of my child solely for the promotion of KVFL.

Parent/Guardian **SIGNATURE** _____ Date _____
By signing this form and giving permission to examine your child and potentially provide eyewear, You are also giving permission to verify Medicaid eligibility and if applicable bill Medicaid ONLY.

Parent/Guardian Printed Name _____

IMPORTANT: Free Eye Exam and Free Glasses are ONLY valid at the time of Kids Vision for Life's visit to your school. This sheet may NOT be presented at any Crown Vision Center location for services or materials.

Patient Health History

Please circle all that apply:

		Details:
Does your child wear glasses?	Yes No	_____
Did your child receive an eye exam last year?	Yes No	_____
Has your child ever injured his/her eyes?	Yes No	_____
Do any of your family members suffer from any medical conditions?	Yes No	_____
Does your child suffer from any medical conditions?	Yes No	_____

Please list any current medications or known allergies: _____

I hereby authorize Kids Vision for Life and their licensed Optometric staff to conduct a comprehensive eye examination on my child and, if needed, to prescribe and dispense spectacle eyewear. I am hereby authorizing FULL disclosure of the results of my child's vision exam, provided by Kids Vision for Life and/or its partners. This information may be shared only with the following individuals: **Myself, My child's school nurse, Crown Vision Center, EssilorVision Foundation, American Optometric Association, and the State of Missouri.** I understand that I may, at any time remove this authorization in writing, however, by doing so I understand that this will take away any services provided by Kids Vision for Life & its partners. I understand if an unauthorized disclosure is made, I may file a formal complaint with the United States Department of Health and Human Services.

COMMUNITY PARTNERS:

ARCHES · Crown Vision Center · essilorvision Foundation · HEALTHY VISION ASSOCIATION