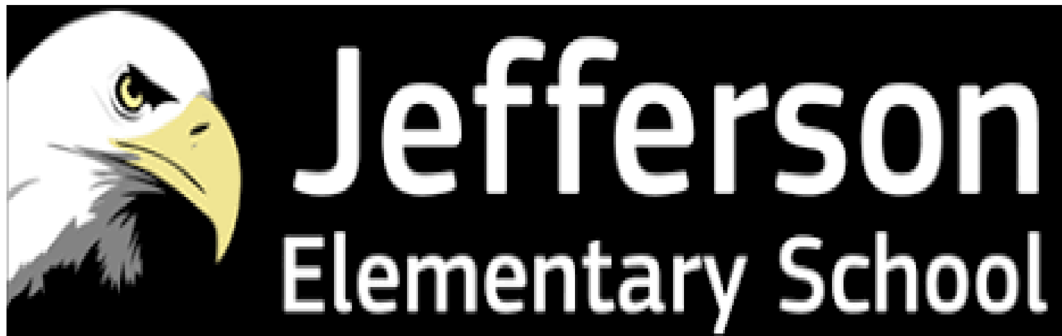


REGISTRATION PACKET 2020-2021

Principal Dr. Leslie Bonner

JEFFERSON ELEMENTARY

REGISTRATION CHECKLIST

STUDENT'S NAME: ______________________________ DATE ENROLLED: ______________________________

VERIFIED BY: ______________________________ SCHOOL: ______________________________

ITEMS NEEDED TO COMPLETE REGISTRATION FOR ALL STUDENTS:

RECEIVED STUDENT HANDBOOK

REGISTRATION/REENTRY APPLICATION

EMERGENCY CONTACT INFORMATION

PARENT PORTAL

NON-RESIDENT ATTENDANCE POLICY

MEDIA RELEASE FORM **TECHNOLOGY USE FORM**

FAMILY SUPPORT PROGRAM ENROLLMENT

HOPEWELL INFORMATION

MEDICAL FORMS (KIDS VISION, AFFINIA, HIPPA, MEDICATION AUTHORIZATION

MISSOURI STATE ID OR DRIVER'S LICENSE **COPY OF BIRTH CERTIFICATE**

COPY OF IMMUNIZATION RECORDS (FOR THE LAST YEAR) **PROOF OF RESIDENCE**

COMPLETED APPLICATION

STUDENT EDUCATIONAL INFORMATION

IDENTIFY SCHOOL STUDENT HAS PREVIOUSLY ATTENDED:

SCHOOL	GRADE	DISTRICT	CITY	STATE

YES NO

Has the student been receiving Section 504 accommodations?
If yes, please provide a copy of the most recent individual accommodations Plan (IAP) and evaluation.

At your child's last school or previous school, was your child receiving help in a resource room for part of the day?

At your child's last school or previous school, was your child receiving help in speech or language therapy?Has your child ever been retained? If YES what grade(s)? _______________

Has your child been evaluated through any other agency?

NEW AND RE-ENTRY STUDENT ***REGISTRATION*** INFORMATION

PARENTS/GUARDIANS PLEASE READ: Please fill out this form completely and present it with your student's required documents to the SLPS representative when completed.

Please Print

STUDENT NAME____
LAST FIRST MIDDLE

ADDRESS______________________________________ APT #______ ZIP CODE **631**____
HOUSE NUMBER STREET NAME TYPE (St., Ave., Ln., etc.)

GRADE______SEX______RACE______BIRTHDATE _______/______/________HOME TEL# ______-______-_________
MONTH DAY YEAR AREA CODE

EMERGENCY # _____-_____-_______EMERGENCY CONTACT ___________________________
AREA CODE

STUDENT'S SOC. SEC. # (Optional)_______-_____-__________DCN/Medicaid # ________________________

SCHOOL AND DISTRICT
LAST ATTENDED____ WITHDRAWAL DATE_______/_______/_______

MOTHER/GUARDIAN NAME____

MOTHER/GUARDIAN EMAIL____ ______________________________CELL PHONE #_____-_____-_______
AREA CODE

FATHER/GUARDIAN NAME____

FATHER/GUARDIAN EMAIL__________________________________CELL PHONE #_____-_____-_______
AREA CODE

***ALL* of the following questions *MUST* be completed in accordance with Missouri Department of Education guidelines.**

- Does student use a language other than English? ☐Yes ☐No Please specify:____________________
- Is a language other than English used at students home? ☐Yes ☐No Please specify:________________
- **Has student ever received special education services?** ☐Yes ☐No Please specify:________________
- **Is student currently in Missouri Children's Division (DFS) custody, or residing in a foster home/residential facility?** Yes ☐ No ☐Caseworker name:_________________________ TEL #_____-_____-________
  AREA CODE
- Have you or a member of your family moved with a child or children within the past 3 years to seek or obtain a temporary or seasonal agricultural, landscaping, or food processing job? ☐Yes ☐ No
  If "Yes," moved from___________________________to___________________________
- Presently, where is student living? *Please check only one box.*
  ☐ In permanent, stable housing with parent(s) ☐ In a shelter ☐ With more than one family in a house or apartment
  ☐ With friends or family members (other than parent/guardian) ☐ In a motel, car, campsite or temporary housing

Missouri Safe Schools Act Disciplinary Information: (Providing false disciplinary information is a Class B misdemeanor.)

- Is student presently under suspension or expulsion from another school or district for violating school board policies relating to weapons, alcohol, drugs, willful infliction of injury to another person? ☐Yes ☐ No
  If "Yes," please describe:____
- Has student been charged or convicted of any felonies? ☐Yes ☐ No
  If "Yes," please describe:____

PARENTS/GUARDIANS PLEASE READ. **By signing below I understand *I must personally* provide residence verification, immunization records, and birth records to my child's assigned school to complete my child's registration, and failure to present the required documents and paperwork will result in denial of enrollment.**

X______________________________________ _________/_________/_________
SIGNATURE OF PARENT / GUARDIAN DATE

11/02/2011 LFK

JEFFERSON ELEMENTARY

EMERGENCY CONTACT INFORMATION & PICK-UP FORM

2020-2021

Date Enrolled: ______________________

Student Name: ___________________________ Room #: ____________Grade: ____________

Date of Birth: ________________ Sex: ____________ Race: ____________

Address: ___________________________________ Phone #: __________________________

City: ____ State: ___________ Zip Code: ____________

Last School Attended: __________________________

City: ____ State: ___________ Zip Code: ____________

Mother/Guardian

Name: _______________________________________ Home Phone #: (______) ______________________

Address: _____________________________________ Cell Phone #: (_______) ______________________

Place of Employment: ____ Address: _______________________

Work Phone #: (______) __________________________ Ext. ____________

Father/Guardian

Name: _______________________________________ Home Phone #: (______) ______________________

Address: _____________________________________ Cell Phone #: (_______) ______________________

Place of Employment: ____ Address: _______________________

Work Phone #: (______) __________________________ Ext. ____________

What mode of transportation will your child use to get home every day, if in person?
Please check only one:

Walker Pick-up Bus Rider

In case of an emergency and the parent can't be reached, please indicate a number where someone may be contacted other than the home phone number. We need a minimum of three (3) phone numbers to ensure we reach someone if the parent can't be reached.

Name	Phone #	*Cell Phone #*
Address	Relationship	
Name	Phone #	Cell Phone #
Address	Relationship	
Name	Phone #	Cell Phone #
Address	Relationship	

Parent Portal

Please fill out this form and include all names of children at this school you would like Parent Portal access to:

Student Name (first and Last)	School	Grade

Please provide an email address to be used for Parent Portal and student information notifications.

Parent name: ____

Parent's E-mail ____

Parent name: ____

Parent's E-mail ____

I understand it is my responsibility to protect my Parent Portal password. I should not share my password with my children. I understand that the Parent Portal system may not be available 24 hours a day due to maintenance on the computer network, weather related interruptions, etc.

____

Parent Signature(s) Printed Name(s)

____

Date

You will need to show your driver's license for verification when you turn this form into the office.
If you send this form to the office you will need to include a copy of your driver's license along with the form.

After your form is processed, you will receive an e-mail listing your sign-on information and password.

Leslie Bonner, Ed. D
Principal, Jefferson Elementary School

Non-Resident Attendance Policy

The following policy is for the 2020-2021 school year.

- **Any student attending Jefferson Elementary School who lives outside the attendance zone, must attend school every day, on time. Unexcused absences or tardiness will result in the student being returned to his/her neighborhood school.**
- **Any student attending Jefferson Elementary School who lives outside the attendance zone, must demonstrate good character and obey school rules daily. A discipline referral at any time will result in the student being returned to his/her neighborhood school.**

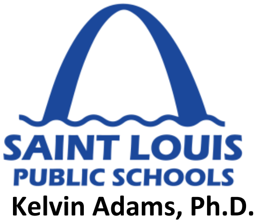
I ___________________________________ have read and accept this Jefferson Elementary Attendance Policy. I have discussed this school policy with my child, and will ensure that he/she will attend school every day, on time and will demonstrate good character and obey all school rules.

I understand that an unexcused absence, tardy and/or discipline referral will result in my child being returned to his/her neighborhood school.

Student Name ____________________________ Student Signature __________________

Parent Name _____________________________ Parent Signature ___________________

Date Signed ____



Kelvin Adams, Ph.D.
Superintendent of Schools

St. Louis Public Schools Media Release Form

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' 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 Birth Date

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.

______________________________ ______________________________

Parent/Legal Guardian Date Signature

____

Printed Name

St. Louis Public Schools

TECHNOLOGY USAGE

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

School Year: 2020-2021

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.

____ _________________________

Signature of Student Date

____

Printed Name (print clearly)

Home Address: ____

____

Home Phone Number: ______-______-______________

____ ____________________________

Signature of Parent/Guardian Date

Implemented: ____________________________________ ____________________________

Name Date

URBAN LEAGUE of Metropolitan St. Louis, Inc. EMPOWERING COMMUNITIES. CHANGING LIVES. | Proud member of United Way of Greater St. Louis | GRACE HILL everyday opportunity | SAINT LOUIS PUBLIC SCHOOLS

The Family Support Program

Student & Family Mentors are Here for You!

Dear Parent or Guardian,

Please welcome new staff members that have joined our school team to provide a fantastic level of support to our students and their families. These **Student and Family Mentors** will work full-time to make sure that resources are available if a student or their family is looking for additional academic, economic, or social support. We want to make sure that students have everything they need to succeed at school - and beyond!

Here are just some of the resources *The Family Support Program* can provide:

Parent Support:

- Help find employment & pursue educational goals
- Parent involved workshops/events on various topics
- Financial, personal, and professional goal-setting
- Mentor & Encourage

Student Support:

- Attendance Rewards (e.g. treats, field trips, field experiences, etc.)
- Mentor & Encourage
- Behavioral & Academic Support
- Academic Acknowledgement
- Summer Enrichment & Fun Field Experiences

Family Support:

- Referrals for emergency utility, housing, food assistance, counseling, & other services
- Community Advocacy
- Crisis Intervention
- Home Visits & Wellness Checks

Student and Family Mentors are available to meet with students and families to discuss strengths, needs and opportunities for growth.

Attached, you will find additional forms. **Please fill these out completely and return to the main office or your student's home room teacher, as soon as possible**! You only need to complete one of these forms per family.

Please let us know if you have any questions. All information given here will be confidential and protected by the school and its partners.

Stay tuned for more about these Student and Family Mentors and how they can help support your family!

Sincerely,

Your Principal

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SAINT LOUIS PUBLIC SCHOOLS

STUDENT'S FULL NAME (F/MI/L)	GENDER	BIRTH DATE (MM/DD/YYYY)	GRADE	TEACHER

HOME ADDRESS	CITY	STATE	ZIP CODE

STUDENT INFORMATION:

Student lives with (check all that apply): ☐ Biological Parent(s) ☐ Aunt/Uncle ☐ Grandparent(s) ☐ Foster Parent(s) ☐ Other ____________

How long has the student lived at his/her current address?

How many people are in the student's household including youth & caregivers (#):

Student's Race/Ethnicity: ☐ African-American ☐ Caucasian/White ☐ Bi-Racial ☐ Multi-Racial ☐Asian ☐ Hispanic ☐ Hawaiian/ Pacific Islander ☐ Native American ☐ Other

Student Qualifies for: ☐ Free Lunch ☐ Reduced Lunch ☐ Pays Full Price

Student's Household Receives:
☐ TANF ☐ Food Stamps ☐ Social Security Benefits ☐ WIC ☐ Other ____________

PARENT/GUARDIAN INFORMATION:

Full Name (F/MI/L):	**Gender:**	**Date of Birth:**	**Relationship to Student(s):**
Address:	**City/State/Zip:**		
Home Phone:	**Cell Phone:**	**Work Phone/Other:**	

Annual Household Income:
☐ $0 to $9,999 ☐ $10,000 to $14,999 ☐ $15,000 to $19,999 ☐ $20,000 to $29,999
☐ $30,000 to $49,000 ☐ $50,000 to $99,999 ☐ $100,000 and Greater

Household Size:

Parent/Guardian Race/Ethnicity: ☐ African-American ☐ Caucasian/White ☐ Bi-Racial ☐ Multi-Racial ☐ Asian ☐ Hispanic ☐ Hawaiian/Pacific Islander ☐ Native American ☐ Other

OTHER PARENT/CAREGIVERS OF STUDENT(S):

Full Name (F/MI/L):	**Gender:**	**Date of Birth:**	**Relationship to Student(s):**
Address:	**City/State/Zip:**		
Home Phone:	**Cell Phone:**	**Work Phone/Other:**	

Emergency Contact Name:	**Emergency Contact Phone:**

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SAINT LOUIS PUBLIC SCHOOLS

Community School Partnerships (CSP)
Family Support Program

Authorization to Release Information

I understand and agree that the following data and information will be released from St. Louis Public school records and confidentiality reviewed and stored in the Family Support Program (CSP) databases through Grace Hill Settlement House (GHSH) for the student(s) ____

---

1. MAP Test Scores (all available)
2. Grades (as needed)
3. Attendance Records
4. Behavioral Information during team meetings
5. Individual Education Plans – (Please circle to indicate if your child has an IEP in place)
   YES NO

In accordance with GHSH's confidentiality policy, this information will not be shared with anyone outside of Grace Hill Settlement House, Urban Strategies, Hopewell Centers, the Little Bit Foundation or CSP-Family Support Program. This consent is effective on the date of my signature below.

I _____________________________________ (parent/guardian) hereby release and waive any claims I may have against the St. Louis Public School District arising from the release of my child's education records to the CSP-Family Support Program, Grace Hill Settlement House, Project LAUNCH, Hopewell Centers and/or the Little Bit Foundation. I also release and waive any claims I may have against the St. Louis Public School District arising from the unauthorized re-release of my child's confidential records by Grace Hill Settlement House, Urban Strategies, Hopewell Centers, the Little Bit Foundation and/or the CSP-Family Support Program.

Parent/Guardian Signature Date

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Family Support Program Confidentiality Form

Permission to Participate
By signing below, I hereby give my permission to have the student(s),

____ participate in the Grace Hill Family Support Program.

____

Parent/Guardian Signature Date

Confidentiality Policy
No Grace Hill Settlement House (GHSH) or Family Support Program (FSP) employee or volunteer/intern will reveal, divulge, publicize or disseminate any oral or written confidential information dealing with GHSH, FSP, the clients it serves, staff members, or interns and will not remove any said documents or media from GHSH or FSP premises without express permission from the GHSH President/CEO or his/her designee.

By signing below, I acknowledge that I have read this GHSH/FSP policy and understand its contents.

____

Parent/Guardian Signature Date

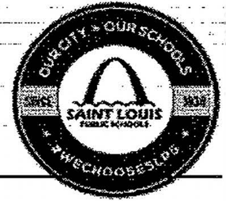
Media Release
By signing below, I give Grace Hill Settlement House/Family Support Program permission to include me in photographs and/or filming for agency information or promotion and to use the photos/film in agency sponsored or agency approved publications, AV productions or special events – include but not limited to newsletters, brochures, reports, presentations, videos, websites, newspaper postings, advertisements.

____

Parent/Guardian Signature Date

For Staff Use Only

Check below if application was submitted by telephone:
☐ Parent/Guardian understands and agrees to the information above. This information was obtained by telephone due to parent/guardian's inability to complete in person. Verbal consent was given by parent/guardian ____________________ to staff ________________________ by telephone on ________________ at ____________. This was witnessed by staff _________________________.



ABCTODAY

AUTHORIZATION FOR RELEASE OF EDUCATION RECORDS

This Authorization constitutes consent for the St. Louis Public School District ("District") to disclose personally identifiable information contained in your child's student educational record.

I understand that the disclosure of personally identifiable information by the District is subject to the requirements of the Family Educational Rights and Privacy Act ("FERPA"). This Authorization complies with FERPA and all relevant District policies and procedures governing student education records[1]. I further understand I have the right: (1) not to release such information, (2) to inspect any written records released pursuant to this consent, and (3) to revoke this consent at any time by delivering written revocation to the District.

1. Purpose of this Authorization: To permit my child's participation in ABCToday, a partnership between St. Louis Public Schools, Big Brothers Big Sisters of Eastern Missouri and other community partners. This program is intended to support Jefferson Elementary School, its students and their parents in celebrating successes and addressing challenges in attendance, behavior, reading and math.

2. Personally identifiable information that may be released: Any and all information contained in my child's academic, attendance and behavior records needed by BBBSEMO to effectively administer ABCToday.

3. Release this information to: BBBSEMO and, as it deems necessary, to its representatives and volunteers involved in executing ABCToday in the District.

4. Duration: This Authorization will continue for the duration of my child's participation in ABCToday! unless sooner withdrawn in writing.

Date: ____________________ Student Name: ____ Student's Date of Birth: ________________

Parent Signature: ____

Parent Name (Printed): ____

Requesting Parent Contact Information:

Address: ____

Phone No.: ____

This information is released subject to confidentiality provisions of appropriate state and federal laws and regulations which prohibit further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

801 N. 11th St. | St. Louis, MO 63101 | Phone: 314-231-3720 | Fax: 314-345-2661

KCP-4514161-1

[1] Please note that federal and state law authorize disclosure of certain student educational records without consent and, as such, this Authorization is not required and does not apply in those situations.

JEFFERSON ELEMENTARY

NURSE INFORMATION FORMS

2020-2021 SCHOOL YEAR

DEPARTMENT OF STUDENT SUPPORT SERVICES
OFFICE OF HEALTH SERVICES

HIPAA-Compliant Authorization for Release of Health Information

Student Name ____ **Date of Birth** ______/______/______

I hereby authorize ____ to release
Primary Care Provider, Address, And Phone
my/my child's health information/records for the purpose listed below to:

School Nurse __________________________________ Phone ____________

School ________________________________ Grade ______ Room # ______

Address ____

Description:
The information to be disclosed consists of:

____

____

____

Purpose:
This information will be used for the following purpose(s):

- ❑ Educational evaluation and program planning.
- ❑ Health assessment and planning for health care services and treatment in school.
- ❑ Medical evaluation and treatment.
- ❑ Other ____

Authorization

This authorization is valid for one calendar year. It will expire on _________________. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

____ __________
Parent Signature Date

____ __________
Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Missouri, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for STD-HIV/AIDS, reproductive health care services, and general medical care.

White = Primary Care Provider **Yellow = Parent or Student*** **Pink = School Health File**

OHS-03 12/2003 (REV 2012)

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

www.kidsforlifestlouis.com

GRADES K-6 ONLY! -FREE EYE EXAM and GLASSES FOR YOUR CHILD

If your child does not pass the vision screening, he/she qualifies to receive an eye exam by an eye doctor and FREE GLASSES from Kids Vision for Life St. Louis.

YES, I want my child to get a FREE vision exam and FREE glasses if needed.

I hereby authorize Crown Vision Centers and their licensed Optometric staff to conduct a comprehensive eye examination on my child an, 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 Crown Vision Center and/or its partners. This information may be shared only with the following individuals. My child's school nurse, Crown Vision Center, Essilor Vision Foundation. American Optometric Association, and the State of Missouri. that I may, at any time remove time remove this authorization in writing, however, by doing I understand that this will take away any services provided provided by Crown Vision Center & 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. 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.

Student's Name: ______________________________ **Date of Birth:** __________________________________

Insurance Provider: ________________________________ **Insurance ID#** _______________ **Gender: M F**

Parent/Guardian Signature: ______________________________________ **Date:** _________________________

Parent/Guardian Printed Name: ____

__ I agree to allow my child to be photographed or filmed solely for the promotion of Kids Vision for Life – St. Louis __________(initials)

IMPORTANT: Free Eye Exam and Free Glasses are ONLY valid at the time of Crown Vision Center'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	________________________________
Are there any problems with his/her vision?	YES	NO	--
Has your child ever injured his/her eye?	YES	NO	--
Does your child suffer from any medical conditions?	YES	NO	--
Do any of your family members suffer from any ? medical condition?	YES	NO	--
Does your child currently take any medication?	YES	NO	_________________________________
Is your child allergic to anything?	YES	NO	--

COMMUNITY PARTNERS:

AFFINIA HEALTHCARE

Affinia Healthcare
1717 Biddle Street • St. Louis, Missouri 63106
Main Number: 314-898-1700 • www.affiniahealthcare.org

AFFINIA HEALTHCARE

SCHOOL BASED DENTAL TREATMENT CONSENT FORM

Affinia Healthcare School Based Dental team can provide dental services at your child's school. Your child's participation is voluntary. **In order for your child to receive these services; you must provide all information requested below. This consent is valid for one year.**

TELL US ABOUT YOUR CHILD

Child's Last Name: ______________________ **First Name:** ________________ **Middle Initial:** _____

Sex: ☐Male ☐Female **Date of Birth** ____/____/______ **Social Security #:**______-______-______

Home Address: ______________________________________ **Zip:** __________

School ______________________________________ **Grade** ________

Parent/Guardian Name (please print): ______________________ **Relationship:** ______________

Cell Phone #: (___) __________ **Home Phone #:** (___) __________ **Work Phone #:**(___) __________

Email Address: ______________________ **Language spoken at home:**______________

Emergency Contact: ______________________ **Relationship:** ______________

Phone #: ______________

Ethnicity, Race, and Housing ***(For Statistic Purposes Only)***

Ethnicity: Hispanic or Latino Non Hispanic or Latino

Race: American Indian or Alaskan Native Asian Black or African American
☐ Native Hawaiian or Other Pacific Islander White

Does your family participate in a Housing Assistance Program? **Yes** **No** **Decline to report**

If yes, which type: Public Housing Section 8 Housing Housing Voucher Program Subsidized Housing
☐ Other (Please List)______________________

Does your family live in a Homeless Shelter or without housing at this time? **Yes** **No** **Decline to report**

Health History: Please check any history of/or difficulty with any of the following:

	Anemia		Diabetes		Hearing Disorder		Mental Disorder
	Asthma		Ear Infections (frequent)		Heart Mumur		Pregnancy
	Back Problems/Scoliosis		Ear Surgery		Hepatitis		Physical Problems
	Behavioral Issues		Eczema		High Blood Pressure		Seizures/Epilepsy
	Bleeding Disorder		Eye/Vision Problems		HIV/Aids		Sickle Cell Disease
	Congenital Heart Defect		Eye Surgery		Kidney Problems		Tuberculosis (TB)
	Cystic Fibrosis		Fainting		Lead Poisoning		Other __________
	Dental Problems		Headaches (frequent)		Liver Disorder		**None of these listed**

Allergies, please describe type: ☐ **Food** ______________ ☐ **Latex** __________
☐**Medication** ☐______________ **Seasonal** ______________ ☐ **Other** __________
Describe type of reaction: ______________________________

Hospitalization date(s), please describe problem:

Surgery date(s), please list reason for surgery:

Please explain any item checked above:

Please list any medications your child is taking:

Any other concerns or comments:

Insurance

Does your child have a <u>medical</u> doctor? Yes No If yes, when was the last time your child saw his/her doctor for a physical or well child exam? Provider/Clinic: ______________________________ Date:

Preferred Pharmacy (If M.D. or Nurse Practitioner feels your child would benefit from medications):
Pharmacy Name: _________________ Pharmacy Location: __________________________ Phone: __________

Does your child have health insurance? **□Yes □ No**
If yes, does your child have health insurance with one of the following plans?

MO Health Net □Yes □No If yes, please specify plan; □ **Healthcare USA** Plan # ______________________
□**Home State** Plan # ________________________ □ **Missouri Care** Plan # ______________________

Missouri Medicaid □ Yes □ No If yes, Plan or DCN #____

Other Medical Insurance □ Yes □ No If yes, Plan Name and #_______________________________

I give consent for payment of authorized insurance carriers to be made on my behalf of Affinia Healthcare for any services furnished to my child. ________ (initial)

Permission for Affinia School Based Services

I give consent for the following (more than one service may be checked, please check with your child's school nurse which services are being offered at your child's school):

Total Care

□ **I interested in Affinia HealthCare affiliated general dentists providing total dental care and oral hygiene instructions to my child which may include <u>dental exams, x-rays, cleanings, fluoride vanish, sealants, fillings, crowns, baby teeth root canals, extractions and spacers placed at the school without my presence. When an exam is performed and cavities are found, Affinia HealthCare will contact me through my child's school nurse indicating all the cavities that have been found, the treatment needed and consent to perform only as needed as stated above.</u> I can also ask to speak to the dental provider if I have questions. . I authorize and direct Affinia HealthCare to bill and collect payment from any Medicaid, insurance, or other third party payer that covers the services provided to this patient, which may be conducted by your insurance carrier and other governing bodies**

* (Children requiring an extraction will be given a second consent form (tooth number) for permission).

□ If ***you <u>do not</u> consent for certain portion the dental treatment, please indicate which service(s) you would like excluded:***

Preventive Care Only

□ I understand and give consent to the Affinia HealthCare affiliated dentists to provide dental care and oral hygiene instructions to my child which will ONLY **include dental exams, x-rays, cleanings, fluoride varnish, sealants at school without my presence unless I withdraw this consent. I understand my child will not receive fillings, crowns, extractions, baby root canals or spacers. I authorize and direct Affinia HealthCare to bill and collect payment from any Medicaid, insurance, or other third party payer that covers the services provided to this patient, which may be conducted by your insurance carrier and other governing bodies.**

****Please note, this consent is valid for one year***

I give permission for Affinia Healthcare School Based Team to provide services for my child. I verify, I have read the information regarding the notice of Privacy Practices (HIPAA). ________ (initial)

I give consent for Affinia Healthcare to use and disclose my child's health information to people involved in my child's care, also including my child's regular doctor and school nurse. ________ (initial)

Parent/Legal Guardian Name (print): ______________________________________ **Date:** __________
Parent/Legal Guardian (signature): ______________________________________ **Date:** __________

Provider Review (signature):____ Date: __________

Submit registration packet by clicking the button below.

Thank you and we look forward to a great 2020-2021 school year!